



**KAISER  
PERMANENTE®**



**Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
Description of Benefits and Member Copayments  
Second 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 those services are covered under the dental plan. The deductible applies to In-Plan and Out-of-Plan Benefits combined per member, per calendar year. Refer to the Point-of-Service Dental Rider for an example of how the combined deductible works. You must pay the full amount charged by the dentist for the services when you receive them, until you meet your deductible. After you meet the deductible, you pay the applicable fee shown below for services provided In-Plan, and you will be reimbursed the amount shown below for services provided Out-of-Plan, up to the annual maximum benefit. You are responsible for the remaining balance for Out-of-Plan Services, and for any amounts that exceed the annual maximum benefit.

**DEDUCTIBLE**

**IN-PLAN:** \$25 per Member  
**OUT-OF-PLAN:** \$50 per Member

**ANNUAL MAXIMUM BENEFIT**

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

**ANNUAL MAXIMUM**

**IN-PLAN:** \$1,000 per calendar year  
**OUT-OF-PLAN:** \$500 per calendar year

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

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

## Description of Benefits and Member Copayments – Second Level POS Plan

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

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
<b><i>Diagnostic Services</i></b>			
D0120	Periodic oral evaluation	\$0	\$19
D0140	Limited oral eval. – problem focused	\$0	\$34
D0150	Comprehensive oral eval.	\$0	\$30
D0180	Comp. perio. eval. – not in conj. with D0150 and limited to 2 per 18 months	\$0	\$30
D0210	Intraoral – compl. series (incl. bitewings)	\$0	\$60
D0220	Intraoral – periapical first film	\$0	\$11
D0230	Intraoral – periapical each additional film	\$0	\$8
D0240	Intraoral – occlusal film	\$0	\$16
D0270	Bitewing – single film	\$0	\$9
D0272	Bitewings – two films	\$0	\$17
D0274	Bitewings – four films	\$0	\$22
D0277	Vertical bitewings – 7 to 8 films	\$0	\$22
D0330	Panoramic film	\$0	\$54
D0460	Pulp vitality tests	\$0	\$22
D0470	Diagnostic casts (not in conj. with Ortho)	\$0	\$45
D0999	Office visit copayment	\$5	No Benefit
<b><i>Preventive Services</i></b>			
D1110	Prophylaxis – adult	\$0	\$41
D1120	Prophylaxis – child	\$0	\$27
D1201	Topical fluoride (incl. proph.) – child	\$0	\$40
D1203	Topical fluoride (without proph.) – child	\$0	\$17
D1204	Topical fluoride excl. proph. – adult (Every 6 Months)	\$0	\$17
D1205	Topical fluoride incl. prophylaxis – age 14+ (Every 6 Months)	\$0	\$45
D1330	Oral hygiene instructions	\$0	\$0
D1351	Sealant – per tooth (up to 16 years of age)	\$0	\$21
D1510	Space maintainer – fixed – unilateral	\$0	\$137
D1515	Space maintainer – fixed – bilateral	\$0	\$252
D1520	Space maintainer – removable – unilateral	\$0	\$189
D1525	Space maintainer – removable – bilateral	\$0	\$252
D1550	Re-cementation of space maintainer	\$0	\$27
<b><i>Restorative Services</i></b>			
D2140	Amalgam – 1 surface, prim. or perm.	\$14	\$39
D2150	Amalgam – 2 surfaces, prim. or perm.	\$18	\$49
D2160	Amalgam – 3 surfaces, prim. or perm.	\$21	\$60
D2161	Amalgam – 4 or more surfaces, prim. or perm.	\$29	\$74
D2330	Resin – based composite – 1 surface, ant.	\$17	\$47
D2331	Resin – based composite – 2 surfaces, ant.	\$21	\$60
D2332	Resin – based composite – 3 surfaces, ant.	\$29	\$74
D2335	Resin – based composite – 4 or more surfaces or involving Incisal angle (ant.)	\$29	\$84
D2391	Resin – based composite – 1 surface, post.	\$18	\$53

## Description of Benefits and Member Copayments – Second Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D2392	Resin-based composite – 2 surfaces, post.	\$25	\$64
D2393	Resin-based composite – 3 surfaces, post.	\$30	\$80
D2394	Resin-based composite – 4 or more surfaces, post.	\$34	\$93
D2510	Inlay – metallic – 1 surface	\$232	\$163
D2520	Inlay – metallic – 2 surfaces	\$261	\$184
D2530	Inlay – metallic – 3 or more surfaces	\$312	\$215
D2542	Onlay metallic – 2 surfaces	\$210	\$147
D2543	Onlay metallic – 3 surfaces	\$210	\$147
D2544	Onlay metallic – 4 or more surfaces	\$210	\$147
D2610	Inlay – porcelain/ceramic –1 surface	\$193	\$205
D2620	Inlay – porcelain/ceramic – 2 surfaces	\$289	\$215
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	\$328	\$231
D2642	Onlay – porcelain/ceramic – two surfaces	\$170	\$121
D2643	Onlay – porcelain/ceramic – 3 surfaces	\$170	\$121
D2644	Dental onlay porcelain 4 or more surfaces	\$170	\$121
D2650	Inlay – resin-based composite –1 surface	\$193	\$205
D2651	Inlay – resin-based composite – 2 surfaces	\$289	\$215
D2652	Inlay – resin-based composite – 3 or more surfaces	\$328	\$231
D2710	Crown – resin (indirect)	\$142	\$100
D2712	Crown 3/4 resin-based composite (exclusive of veneers)	\$142	\$100
D2740	Crown – porcelain/ceramic substrate	\$392	\$273
D2750	Crown – porcelain fused to high noble metal	\$385	\$268
D2751	Crown – porcelain fused to predom. base metal	\$340	\$236
D2752	Crown – porcelain fused to noble metal	\$363	\$252
D2780	Crown – 3/4 cast high noble metal	\$375	\$257
D2781	Crown – 3/4 cast predom. base metal	\$375	\$257
D2782	Crown – 3/4 cast noble metal	\$375	\$257
D2790	Crown – full cast high noble metal	\$375	\$263
D2791	Crown – full cast predominantly base metal	\$335	\$236
D2792	Crown – full cast noble metal	\$357	\$247
D2794	Crown – Titanium	\$375	\$263
D2910	Recement inlay	\$27	\$19
D2915	Recement cast or prefab. post and core	\$27	\$19
D2920	Recement crown	\$27	\$19
D2930	Prefab. stainless steel crown – prim. Tooth	\$86	\$58
D2931	Prefab. stainless steel crown – perm. Tooth	\$86	\$63
D2932	Prefab. resin crown	\$86	\$58
D2934	Prefab. steel crown – prim. Tooth	\$86	\$58
D2940	Sedative filling	\$29	\$20
D2950	Core buildup, including any pins	\$86	\$58
D2951	Pin retention – per tooth, in add. to restoration	\$16	\$11
D2952	Cast post and core in add. to crown	\$113	\$79
D2954	Prefab. post and core in add. to crown	\$96	\$68
D2980	Crown repair, by report	\$65	\$47
<b>Endodontic Services</b>			
D3110	Pulp cap – direct (excl. final restoration)	\$7	\$22
D3120	Pulp cap – indirect (excl. final restoration)	\$6	\$19
D3220	Therapeutic pulpotomy (excl. final restoration)	\$21	\$59
D3310	Anterior (excluding final restoration)	\$91	\$257

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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D3320	Bicuspid (excluding final restoration)	\$136	\$305
D3330	Molar (excluding final restoration)	\$170	\$467
D3346	Retreatment – anterior	\$112	\$299
D3347	Retreatment – bicuspid	\$165	\$354
D3348	Retreatment – molar	\$195	\$543
D3351	Apexification/recalcification – initial visit	\$40	\$105
D3352	Apex./recalcification – interim medication replacement	\$40	\$105
D3353	Apexification/recalcification – final visit	\$40	\$105
D3410	Apicoectomy/periradicular surgery – ant.	\$119	\$331
D3421	Apicoectomy – bicuspid (first root)	\$131	\$362
D3425	Apicoectomy – molar (first root)	\$148	\$404
D3426	Apicoectomy (each add. root)	\$45	\$126
D3430	Retrograde filling – per root	\$40	\$105
D3450	Root amputation – per root	\$73	\$205
D3920	Hemisection (incl. any root removal)	\$68	\$189
<b>Periodontic Services</b>			
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	\$96	\$263
D4211	Gingivectomy or gingivoplasty –1 to 3 teeth, per quadrant	\$29	\$84
D4240	Gingival flap procedure, including root planing – 4 or more contiguous teeth	\$119	\$326
D4241	Gingival flap procedure, incl. root planing – 1 to 3 teeth, per quadrant	\$60	\$163
D4249	Clinical crown lengthening – hard tissue	\$131	\$362
D4260	Osseous (bone) surgery – 4 or more per quad.	\$187	\$525
D4261	Osseous (bone) surgery – 1 to 3 teeth, per quad.	\$94	\$263
D4263	Bone replacement graft – first site in quad.	\$125	\$236
D4265	Biologic material to aid in soft/osseous tissue	\$63	\$119
D4268	Surgical revision procedure, per tooth	\$119	\$331
D4270	Pedicle soft tissue graft procedure	\$125	\$352
D4271	Free soft tissue graft procedure – incl. donor site	\$148	\$410
D4275	Soft tissue allograft	\$148	\$410
D4276	Combined connective tissue and double pedicle	\$125	\$352
D4320	Provisional splinting – intracoronal	\$40	\$116
D4321	Provisional splinting – extracoronal	\$40	\$116
D4341	Perio scaling and root planing – 4 or more per quad.	\$40	\$116
D4342	Perio scaling and root planing – 1 to 3 teeth, per quad.	\$20	\$58
D4355	Full mouth debridement	\$39	\$105
D4910	Periodontal maintenance	\$21	\$60
<b>Prosthetics – Removable</b>			
D5110	Complete denture – maxillary	\$409	\$284
D5120	Complete denture – mandibular	\$409	\$284
D5130	Immediate denture – maxillary	\$442	\$310
D5140	Immediate denture – mandibular	\$442	\$310
D5211	Maxillary partial denture – resin base (incl. any conventional clasps, rests and teeth)	\$363	\$252
D5212	Mandibular partial denture – resin base (incl. any conventional clasps, rests and teeth)	\$363	\$252
D5213	Maxillary partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	\$448	\$310
D5214	Mandibular partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	\$448	\$310
D5225	Maxillary partial denture	\$448	\$310
D5226	Mandibular partial denture	\$448	\$310

## Description of Benefits and Member Copayments – Second Level POS Plan

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D5281	Removable unilateral partial denture – 1 piece cast metal (incl. clasps and teeth)	\$244	\$168
D5410	Adjust complete denture – maxillary	\$20	\$15
D5411	Adjust complete denture – mandibular	\$20	\$15
D5421	Adjust partial denture – maxillary	\$20	\$15
D5422	Adjust partial denture – mandibular	\$20	\$15
D5510	Repair broken complete denture base	\$46	\$33
D5520	Replace missing/broken teeth (each tooth)	\$37	\$26
D5610	Repair resin denture base	\$44	\$30
D5620	Repair cast framework	\$54	\$37
D5630	Repair or replace broken clasp	\$51	\$36
D5640	Replace broken teeth – per tooth	\$39	\$27
D5650	Add tooth to existing partial denture	\$49	\$34
D5660	Add clasp to existing partial denture	\$57	\$42
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$217	\$151
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$217	\$151
D5710	Rebase complete maxillary denture	\$153	\$105
D5711	Rebase complete mandibular denture	\$153	\$105
D5720	Rebase maxillary partial denture	\$153	\$105
D5721	Rebase mandibular partial denture	\$153	\$105
D5730	Reline compl.maxillary denture (chairside)	\$91	\$63
D5731	Reline compl. mandibular denture (chairside)	\$91	\$63
D5740	Reline maxillary part. denture (chairside)	\$91	\$63
D5741	Reline mandibular part. denture (chairside)	\$91	\$63
D5750	Reline compl. maxillary denture (lab)	\$125	\$84
D5751	Reline compl. mandibular denture (lab)	\$125	\$84
D5760	Reline maxillary part. denture (lab)	\$125	\$84
D5761	Reline mandibular part. denture (lab)	\$125	\$84
D5820	Interim part. denture (maxillary)	\$158	\$110
D5821	Interim part. denture (mandibular)	\$158	\$110
D5850	Tissue conditioning, maxillary	\$44	\$32
D5851	Tissue conditioning, mandibular	\$41	\$30
<b><i>Prosthetics – Fixed</i></b>			
D6205	Pontic – indirect resin based composite	\$142	\$100
D6210	Pontic – cast high noble metal	\$369	\$257
D6211	Pontic – cast pred. base metal	\$340	\$221
D6212	Pontic – cast noble metal	\$328	\$226
D6214	Pontic – titanium	\$369	\$257
D6240	Pontic – porcelain fused to high noble metal	\$375	\$263
D6241	Pontic – porcelain fused to predom. Metal	\$328	\$226
D6242	Pontic – porcelain fused to noble metal	\$357	\$247
D6545	Retainer – cast metal for resin bonded fixed	\$142	\$100
D6602	Inlay – cast high noble metal, 2 surfaces	\$287	\$203
D6603	Inlay – cast high noble metal, 3 or more surfaces	\$343	\$237
D6604	Inlay – cast predom. base metal, 2 surfaces	\$287	\$203
D6605	Inlay – cast predom. base metal, 3 or more surfaces	\$296	\$205
D6606	Inlay – cast noble metal, 2 surfaces	\$261	\$184
D6607	Inlay – cast noble metal, 3 or more surfaces	\$312	\$215
D6610	Onlay – cast high noble metal, 2 surfaces	\$334	\$158
D6611	Onlay cast high noble metal, 3 or more surfaces	\$366	\$172

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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D6612	Onlay – cast predom. base metal, 2 surfaces	\$288	\$135
D6613	Onlay – cast predom. base metal, 3 or more surfaces	\$319	\$150
D6614	Onlay – cast noble metal, 2 surfaces	\$303	\$143
D6615	Onlay cast noble metal, 3 or more surfaces	\$334	\$158
D6624	Inlay – titanium	\$343	\$237
D6634	Onlay – titanium	\$366	\$172
D6710	Crown – indirect resin based composite	\$142	\$100
D6750	Crown – porcelain fused to high noble metal	\$382	\$268
D6751	Crown – porcelain fused to predom. base metal	\$340	\$236
D6752	Crown – porcelain fused to noble metal	\$363	\$252
D6780	Crown – 3/4 cast high noble metal	\$357	\$242
D6781	Crown – 3/4 cast predom. base metal	\$357	\$242
D6782	Crown – 3/4 cast noble metal	\$357	\$242
D6790	Crown – full cast high noble metal	\$375	\$263
D6791	Crown – full cast predom. base metal	\$335	\$236
D6792	Crown – full cast noble metal	\$357	\$247
D6794	Crown – titanium	\$368	\$263
D6930	Recement fixed partial denture	\$37	\$26
<b>Oral Surgery</b>			
D7111	Coronal remnants – deciduous tooth	\$9	\$23
D7140	Extraction, erupted tooth or exposed root	\$17	\$46
D7210	Surgical removal of erupted tooth	\$40	\$105
D7220	Removal of impacted tooth – soft tissue	\$45	\$131
D7230	Removal of impacted tooth – part. Bony	\$57	\$163
D7240	Removal of impacted tooth – compl. Bony	\$68	\$194
D7250	Removal of residual tooth roots	\$45	\$121
D7260	Oroantral fistula closure	\$108	\$305
D7261	Primary closure of a sinus perforation	\$108	\$305
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$57	\$173
D7280	Surgical access of an unerupted tooth	\$91	\$257
D7282	Mobiliz. of erupted or malpos. tooth–aid erupted	\$79	\$215
D7283	Placement of device	\$46	\$129
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$45	\$126
D7286	Biopsy of oral tissue – soft (all others)	\$51	\$142
D7287	Cytology sample collection	\$26	\$71
D7288	Brush biopsy – transepithelial sample collection	\$26	\$71
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$12	\$36
D7310	Alveoloplasty in conj. with extractions – per quad.	\$45	\$126
D7311	Alveoloplasty in conj. with extractions	\$22	\$63
D7320	Alveoloplasty not in conj. with extractions – per quad.	\$62	\$173
D7321	Alveoloplasty not in conj. with extractions	\$31	\$87
D7410	Excision of benign lesion up to 1.25 cm	\$62	\$168
D7411	Excision of benign lesion > 1.25 cm	\$96	\$273
D7412	Excision of benign lesion, complicated	\$106	\$300
D7450	Removal of benign odon cyst/tumor – diam <= 1.25cm	\$57	\$158
D7451	Removal of benign odon cyst/tumor – diam > 1.25cm	\$102	\$289
D7460	Removal of benign nonodon cyst/tumor – diam <=1.25cm	\$62	\$173
D7461	Removal of benign nonodon cyst/tumor – diam > 1.25cm	\$119	\$326
D7471	Removal of lateral exostosis	\$91	\$257

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ADA CODE	DESCRIPTION OF SERVICES	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D7472	Removal of torus palatinus	\$91	\$257
D7473	Removal of torus mandibularis	\$91	\$257
D7485	Surgical reduction of osseous tuberosity	\$91	\$257
D7510	Incision and drainage of abscess – intraoral soft tissue	\$29	\$79
D7511	Incision and drainage of abscess – intraoral	\$36	\$99
D7520	Incision/drainage of abscess – extra. soft tissue	\$45	\$121
D7521	Incision and drainage of abscess	\$57	\$151
D7530	Foreign body removal from muc./skin/subcut tissue	\$34	\$95
D7550	Partial ostect/sequestrect non-vital bone removal	\$45	\$242
D7910	Suture of recent small wounds up to 5 cm	\$16	\$44
D7911	Complicated suture – up to 5 cm	\$29	\$74
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$74	\$210
D7963	Frenuloplasty	\$73	\$210
D7970	Excision of hyperplastic tissue – per arch	\$51	\$142
D7971	Excision of pericoronal gingiva	\$29	\$79
D7972	Surgical reduction of fibrous tuberosity	\$51	\$142
<b>Orthodontics</b>			
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$2,098	No Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$2,098	No Benefit
D8670	Periodic orthodontic treatment visit (as part of contract)	\$0	No Benefit
<b>Additional Procedures</b>			
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$11	\$29
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0	\$0
D9220	Deep sedation/general anesthesia – first 30 minutes	\$62	\$173
D9221	Deep sedation/general anesthesia – each add. 15 min	\$19	\$54
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$7	\$21
D9241	Intrav conscious sedation/analgesia – first 30 min	\$51	\$142
D9242	Intrav conscious sedation/analgesia each addtl. 15 min	\$0	\$135
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$13	\$47
D9440	Office visit – after reg.scheduled hours	\$27	No Benefit
D9910	App.of desensitizing medication	\$5	\$16
D9940	Occlusal guard, by report	\$74	\$278
D9942	Repair and/or relin of occlusal guard	\$22	\$84
D9951	Occlusal adjustment – limited	\$14	\$59
D9952	Occlusal adjustment – complete	\$56	\$247

### POS Exclusions and Limitations

**EXCLUSIONS – Neither Health Plan nor Dental Administrator provides coverage for the following:**

1. Services for injuries or conditions, which are covered under worker's compensation and/or employer's liability laws.
2. Services, which are provided without cost to Subscribers by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
3. Services, which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
4. Cosmetic or aesthetic dentistry.
5. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan.
7. Hospitalization for any dental procedure.
8. Treatment for conditions resulting from major disaster, epidemic or war, including declared or undeclared war or acts of war.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services that cannot be performed because of the general health of the patient.
11. Implantation and related restorative procedures.
12. Services not listed as a Covered Dental Service as described in this Description of Benefits and Member Copayments.
13. Services related to the treatment of TMJ (Temporal Mandibular Joint disorder).
14. Elective surgery including, but not limited to extraction of non-pathologic, asymptomatic impacted teeth.
15. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
16. Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
17. Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan.
18. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan.
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. Orthodontic treatment for adults.

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24. Orthodontic treatment related to Temporomandibular Joint (TMJ) dysfunction.
25. Occlusal guards, except for the purpose of controlling habitual grinding.

### LIMITATIONS

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

Claims can be mailed to:  
Dominion Dental Services USA, Inc.  
P.O. Box 1920  
Bowie, MD 20717-1920

File electronically using our Payor ID of DOM01.