Kaiser Permanente Dental Choice PPO

You may go to any participating dentist to utilize in-network covered benefits or receive care from a non-participating dentist. For services performed by a Dental Specialist, your dental office will initiate a treatment plan or recommend seeing a participating Dental Specialist if the services are medically necessary and outside the scope of general dentistry. A referral is not required, you may see any participating Dental Specialist in the network.

If a participating Dental Specialist is not available within your service area, upon approval, we will make arrangements for you to see an out-of-network dentist and apply in-network benefits. For a list of participating dentists, please visit us online at **https://client.libertydentalplan.com/kp-cova/FindADentist**.

For information on locating a Participating Dental Provider, please contact us Toll Free at **1-888-764-5393**/TTY: 1-877-855-8039, Monday through Friday, 7:30am to 6:00pm, EST.

Out-of-network benefits are calculated using a maximum allowable charge. You are responsible for any amount charged which exceeds the maximum allowable charge per procedure. If you receive treatment from a non-participating dentist, you may be required to make payment in full at the time of service. You may then submit a claim to LIBERTY Dental Plan for benefit payment.

Benefits underwritten by LIBERTY Dental Plan of Virginia, Inc.

LIBERTY DENTAL PLAN | KAISER PERMANENTE®

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Covered Dental Services	In-Network	Out-of-Network
Annual Deductible – This is the combined in and out-of-network amount that must be met before the plan covers benefits. The first Member to meet the Individual Deductible has met it for the rest of the plan year. The family deductible is met by combining eligible expenses of up to three covered family Members.	$25 Individual $75 Family	$50 Individual $150 Family
Annual Maximum – This is the maximum limit the plan will pay in benefits per plan year. This combined limit applies to both in and out-of-network services for Type 1, 2, and 3.	$1,000	$500
Orthodontic Lifetime Maximum	$1,000	Not Covered
Waiting Periods – Waiting periods do not apply to Type 1, 2, 3 and 4 services.	None	None
Type 1, Diagnostic & Preventive Services – Oral Exams, Radiographic Images (x-rays), Cleanings, Fluoride, Sealants, Space Maintainers, Palliative Treatment	100% Subject to deductible	60% Subject to deductible
Type 2, Basic Benefits – Fillings (Amalgam, Composite), Endodontic Services, Periodontal (Surgical and Non-Surgical) Services, Extractions, Oral Surgery, Occlusal Guard	80% Subject to deductible	50% Subject to deductible
Type 3, Major Benefits – Inlays, Onlays, Crowns, Dentures; Fixed and Removable (Complete or Partial), Complete and Partial Denture Related Services (Adjustment, Repairs, and Relines or Rebase), Sedation/Anesthesia, Therapeutic Drugs, Teledentistry	50% Subject to deductible	35% Subject to deductible
Type 4, Orthodontia (Covered for members up to age 19) – Banding, Removable and Fixed Appliance Therapy, and Retention Treatment	50% Subject to deductible	Not Covered

For a complete list of terms, benefits, limitations and exclusions, please refer to your Certificate of Insurance. Benefits underwritten by LIBERTY Dental Plan of Virginia, Inc.

LIBERTY DENTAL PLAN | KAISER PERMANENTE®

Service Class	Service Description	Limitation	In Network	Out-of-Network
			Plan Pays	Plan Pays
1	Oral Evaluations	Two every 12 months, Comprehensive exam every 36 months	100%	60%
1	Limited or Problem Focused Exams	One every 12 months	100%	60%
1	Cleaning (Prophylaxis)	Two every 12 months, including Scaling with Inflammation	100%	60%
1	Fluoride Treatment	One every 12 months, up to age 16	100%	60%
1	Bitewing Radiographic Images	Two every 12 months	100%	60%
1	Periapical Images	No limitation	100%	60%
1	Full Mouth or Panoramic Radiographic Images	One every 60 months	100%	60%
1	Sealants	One per tooth in a lifetime, up to age 16, limited to permanent 1st and 2nd molars	100%	60%
1	Space Maintainers including Re-cement and Removal	Covered for primary teeth	100%	60%
1	Palliative (emergency) Treatment	Only covered if no service other than exams and/or x-rays performed on the same date of service	100%	60%
2	Fillings, Amalgam and Composite	One per tooth, per surface every 24 months	80%	50%
2	Pin Retention	Multiple pins on the same tooth are allowable as one pin	80%	50%
2	Pulp Cap, Pulpal Therapy, Pulpotomy	No limitation	80%	50%
2	Root Canal	Not covered if pulp chamber was opened prior to effective date	80%	50%
2	Apicoectomy	No limitation	80%	50%
2	Retreatment of Root Canal	No limitation	80%	50%
2	Retrograde Fillings	One per root in a lifetime	80%	50%

Service Class	Service Description	Limitation	In Network	Out-of-Network
			Plan Pays	Plan Pays
2	Gingivectomy, Osseous Surgery, Gingival Flap Procedure	No limitation	80%	50%
2	Pedicle or Tissue Grafts	One in a lifetime, per site or quadrant	80%	50%
2	Periodontal Scaling and Root Planing	One per site or quadrant every 24 months	80%	50%
2	Scaling with Gingival Inflammation	One every 24 months, including Prophylaxis Cleanings	80%	50%
2	Full Mouth Debridement	One in a lifetime	80%	50%
2	Antimicrobial agent, per tooth, administered by Dentist	No limitation	80%	50%
2	Periodontal Maintenance	Two every 12 months, following periodontal services	80%	50%
2	Extractions; including removal of teeth, Tooth Root	No limitation	80%	50%
2	Coronectomy, intentional partial tooth removal	One in a lifetime, per tooth	80%	50%
2	Oral Surgery; Tooth Reimplantation, Tooth Transplantation, Removal of Exostosis, Incisional Biopsy of Tissue, Alveoloplasty, Excision of Tumor or Cyst, Incision and Drainage of Abscess, Frenulectomy, Frenuloplasty, Excision of Pericoronal Gingiva	No limitation	80%	50%
2	Occlusal Guard (Night Guard)	One every 60 months	80%	50%
3	Study Model (Diagnostic Cast)	One every 36 months	80%	50%
3	Inlay, Onlay, Single Crown and Bridges; Resin Based, Metal, Porcelain, Noble, High Noble, Ceramic	One per tooth every 7 year period from placement, limited to a tooth that is unable to be restored with a filling	50%	35%

Service Class	Service Description	Limitation	In Network	Out-of-Network
			Plan Pays	Plan Pays
3	Re-cement/Re-bond of Inlay, Onlay, or Crown	One per tooth every 12 months, not payable within 12 months of placement	50%	35%
3	Core Buildup	No limitation	50%	35%
3	Post and Core, In Addition to Crown	No limitation	50%	35%
3	Inlay, Onlay, Single Crown, and Bridge Repairs	One per tooth every 24 months	50%	35%
3	Stainless Steel Crowns	One per tooth in a lifetime, limited to primary, for members up to age 14	50%	35%
3	Removable Prosthetic Services; Complete or Partial Dentures	One per arch every 7-year period, that cannot be repaired by reline, rebase, adjustment or repair	50%	35%
3	Complete or Partial Denture Adjustments	One per arch every 24 months	50%	35%
3	Repair Complete or Partial Denture	Once per arch every 24 months	50%	35%
3	Add tooth to an Existing Partial Denture	No limitation	50%	35%
3	Reline or Rebase of Denture or Partial	One per arch every 24 months, not payable within 24 months of placement	50%	35%
3	Tissue Conditioning	One per arch every 7-year period, not payable when performed within 6 months of denture placement	50%	35%
3	General Anesthesia, IV Sedation	GA and IV Sedation covered with Oral Surgery or Periodontal Surgery	50%	35%
3	Nitrous Oxide/Analgesia	No limitation	50%	35%
3	Therapeutic Drugs	No limitation	50%	35%
3	Teledentistry	Two every 12 months	50%	35%
4	Orthodontic Services; Including Banding, Removable and Fixed Appliance Therapy, and Retention Treatment	No limitation	50%	Not Covered

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Plan Exclusions

The following services are not covered under this Dental Plan:

- Any procedures not listed on this Plan.
- Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
- Services which are covered under worker's compensation or employer's liability laws.
- Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary, excluding Orthodontia.
- Oral surgery for setting of fractures and/or dislocations.
- Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Plan based on generally accepted dental standards of care.
- For elective procedures, including prophylactic extraction of third molars.
- Hospitalization for any dental procedure.
- Replacement of Dentures, Crowns, Appliances or Bridgework that have been lost, stolen or damaged.
- Periodontal Splinting.
- Replacement of dentures, bridges, inlays, onlays or single crowns that can be repaired and/or restored to normal function.
- Implants and implant related services, including removal of implant.
- Diagnosis and/or treatment of temporomandibular disorder (TMD), including syndromes, problems, and/or occlusal conflict.
- Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, or while on active duty as a member of the armed forces of any nation.
- Services that restore tooth structure due to attrition, erosion, abrasion, and increasing vertical dimension.
- Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
- Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
- Broken appointments.

Benefits underwritten by LIBERTY Dental Plan of Virginia, Inc.

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