Great value, fixed fees, limited costs

COMMONWEALTH OF VIRGINIA
JULY 1, 2017 – JUNE 30, 2018

A GUIDE TO YOUR DENTAL BENEFITS

Adult Second Level Point-of-Service plan

In the event of ambiguity, or a conflict between this summary and the *Evidence of Coverage (EOC)*, 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.

KAISER PERMANENTE®

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

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

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

In-plan

You pay a $5 copay for in-plan office visits and low copayments for preventive care procedures such as:

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

Out-of-plan

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

Choosing a dentist

In-plan dental providers

You may select any general dentist from our network of participating dentists. When you choose a plan dentist, your out-of-pocket expenses are lower and there are no claims to submit.

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

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

Out-of-plan dental providers

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

Deductibles and annual maximums

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

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

[1]Dominion National, based on annual review of utilization data, network survey, and analysis report, 3rd quarter 2016.
[2]Mid-Atlantic area includes Washington, DC, and parts of Maryland and Virginia.

Make appointments

On or after your effective date of coverage, you can make an appointment with any participating (in-plan) dentist. You can also choose to visit any other licensed dentist not in the plan to receive your care (out-of-plan). Make sure you bring your Kaiser Permanente medical ID card to your appointment. There is no separate dental ID card.

How can I submit a claim?

Claims only need to be submitted when you receive care from an out-of-plan dentist. You may be expected to pay the dentist the full amount at the time of service and then submit a claim to Dominion National for reimbursement. You must submit the claim within 365 days of the date of service. Reimbursement is capped at the amount shown on the out-of-plan copayment schedule.

Claims should be mailed to:
Dominion National
P.O. Box 1126
Elk Grove, IL 60009

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

Dedicated member service

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

Toll free phone: **855-733-7524; TTY 711**

Fax: **855-485-0115**

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

Web: **DominionNational.com/kaiserdentists**

Making changes online

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 return email.

Second Level POS plan – 2017 schedule of copayments

Procedures not shown in this list are not covered. Refer to the description of your dental benefit in your *Evidence of Coverage* 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 plan 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 plan year. 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 copayment 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.

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 plan 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 plan year.

IN-PLAN: $1,000 per plan year
OUT-OF-PLAN: $500 per plan year

The dental plan is administered by Dominion National.

NOTE:

The dental copayment schedule is reviewed annually and is subject to change effective July 1 of each year. If you have any questions concerning this copayment schedule, contact Dominion for details at **703-518-5338** or toll-free at **855-733-7524 (TTY 711)**, Monday through Friday, 7:30 a.m. to 6 p.m.

Your dental plan administrator and health plan carrier – Dominion National (Dominion) and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – are working together to help you be well, live well, and thrive.

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
	DIAGNOSTIC SERVICES		
D0120	Periodic oral evaluation	$0	$20
D0140	Limited oral eval – problem focused	$0	$35
D0150	Comprehensive oral eval – new or established patient	$0	$31
D0180	Comp. periodontal eval – new or established patient	$0	$31
D0210	Intraoral – complete series (including bitewings)	$0	$62
D0220	Intraoral – periapical first film	$0	$12
D0230	Intraoral – periapical each add. film	$0	$9
D0240	Intraoral – occlusal film	$0	$17
D0270	Bitewing – single film	$0	$10

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D0272	Bitewings – two films	$0	$18
D0274	Bitewings – four films	$0	$23
D0277	Vertical bitewings – 7 to 8 films	$0	$23
D0330	Panoramic film	$0	$56
D0460	Pulp vitality tests	$0	$23
D0470	Diagnostic casts	$0	$45
D0999	Unspecified diagnostic procedure, by report	$5	N/B
PREVENTIVE SERVICES			
D1110	Prophylaxis (cleaning) – adult	$0	$42
D1120	Prophylaxis (cleaning) – child	$0	$27
D1206	Topical application of fluoride varnish	$0	$18
D1208	Topical application of fluoride	$0	$18
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant – per tooth	$0	$22
D1352	Prev resin rest. mod/high caries risk – perm. tooth	$0	$22
D1510	Space maintainer – fixed – unilateral	$0	$137
D1515	Space maintainer – fixed – bilateral	$0	$252
D1520	Space maintainer – removable – unilateral	$0	$189
D1525	Space maintainer – removable – bilateral	$0	$252
D1550	Re-cementation of space maintainer	$0	$27
RESTORATIVE SERVICES			
D2140	Amalgam – 1 surface, prim. or perm.	$16	$40
D2150	Amalgam – 2 surfaces, prim. or perm.	$20	$50
D2160	Amalgam – 3 surfaces, prim. or perm.	$23	$62
D2161	Amalgam – 4 or more surfaces, prim. or perm.	$33	$76
D2330	Resin-based composite – 1 surface, ant.	$19	$48
D2331	Resin-based composite – 2 surfaces, ant.	$23	$62
D2332	Resin-based composite – 3 surfaces, ant.	$33	$76
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (ant.)	$33	$86

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D2391	Resin-based composite – 1 surface, post.	$20	$55
D2392	Resin-based composite – 2 surfaces, post.	$28	$66
D2393	Resin-based composite – 3 surfaces, post.	$34	$82
D2394	Resin-based composite – 4 or more surfaces, post.	$38	$95
CROWNS & BRIDGES*			
D2510	Inlay-metallic – 1 surface	$258	$167
D2520	Inlay-metallic – 2 surfaces	$291	$188
D2530	Inlay-metallic – 3 or more surfaces	$348	$220
D2542	Onlay-metallic – 2 surfaces	$234	$150
D2543	Onlay-metallic – 3 surfaces	$234	$150
D2544	Onlay-metallic – 4 or more surfaces	$234	$150
D2610	Inlay-porcelain/ceramic – 1 surface	$215	$210
D2620	Inlay-porcelain/ceramic – 2 surfaces	$321	$220
D2630	Inlay-porcelain/ceramic – 3 or more surfaces	$365	$236
D2642	Onlay-porcelain/ceramic – 2 surfaces	$189	$124
D2643	Onlay-porcelain/ceramic – 3 surfaces	$189	$124
D2644	Dental onlay porcelain – 4 or more surfaces	$189	$124
D2650	Inlay-resin-based composite – 1 surface	$215	$210
D2651	Inlay-resin-based composite – 2 surfaces	$321	$220
D2652	Inlay-resin-based composite – 3 or more surfaces	$365	$236
D2710	Crown-resin (indirect)	$159	$102
D2712	Crown-3/4 resin-based composite (exclusive of veneers)	$159	$102
D2740	Crown-porcelain/ceramic substrate	$437	$279
D2750	Crown-porcelain fused to high noble metal	$428	$274
D2751	Crown-porcelain fused to predom. base metal	$378	$241
D2752	Crown-porcelain fused to noble metal	$404	$258
D2780	Crown-3/4 cast high noble metal	$418	$263
D2781	Crown-3/4 cast predom. base metal	$418	$263
D2782	Crown-3/4 cast noble metal	$418	$263

*All copayments exclude the cost of noble and precious metals. An additional copayment will be charged if these materials are used.

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D2790	Crown – full cast high noble metal	$418	$269
D2791	Crown – full cast predom. base metal	$373	$241
D2792	Crown – full cast noble metal	$397	$252
D2794	Crown – titanium	$418	$269
D2910	Recement inlay	$30	$20
D2915	Recement cast or prefab. post and core	$30	$20
D2920	Recement crown	$30	$20
D2930	Prefab. stainless steel crown – prim. tooth	$96	$60
D2931	Prefab. stainless steel crown – perm. tooth	$96	$65
D2932	Prefab. resin crown	$96	$60
D2934	Prefab. steel crown – prim. tooth	$96	$60
D2940	Sedative filling	$33	$21
D2941	Interim therapeutic rest., prim. dentition	$7	$30
D2950	Core buildup, including any pins	$96	$60
D2951	Pin retention – per tooth, in addition to restoration	$18	$12
D2952	Cast post and core in addition to crown	$126	$81
D2954	Prefab. post and core in addition to crown	$107	$70
D2980	Crown repair, by report	$72	$48
ENDODONTIC SERVICES			
D3110	Pulp cap – direct (excl. final restoration)	$7	$23
D3120	Pulp cap – indirect (excl. final restoration)	$6	$20
D3220	Therapeutic pulpotomy (excl. final restor.)	$23	$61
D3310	Anterior (excl. final restoration)	$101	$263
D3320	Bicuspid (excl. final restoration)	$151	$312
D3330	Molar (excl. final restoration)	$189	$477
D3346	Retreatment – anterior	$125	$305
D3347	Retreatment – bicuspid	$184	$362
D3348	Retreatment – molar	$217	$554
D3351	Apexification/recalcification – initial visit	$44	$108
D3352	Apexification/recalcification – interim medication replacement	$44	$108

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D3353	Apexification/recalcification – final visit	$44	$108
D3355	Pulpal regeneration – initial visit	$44	$108
D3356	Pulpal regeneration – interim medication replacement	$44	$108
D3357	Pulpal regeneration – completion of treatment	$44	$108
D3410	Apicoectomy/periradicular surgery – anterior	$132	$338
D3421	Apicoectomy – bicuspid (first root)	$146	$370
D3425	Apicoectomy – molar (first root)	$165	$413
D3426	Apicoectomy (each add. root)	$50	$129
D3427	Periradicular surgery w/o apicoectomy	$110	$318
D3428	Bone graft in conj. w/periradicular surgery, per tooth, single site	$140	$241
D3429	Bone graft in conj. w/periradicular surgery each additional, contiguous tooth in same site	$70	$121
D3430	Retrograde filling – per root	$44	$108
D3431	Biologic materials to aid soft/osseous tissue regeneration in conjunction w/periradicular surgery	$70	$122
D3450	Root amputation – per root	$81	$210
D3920	Hemisection, not inc. root canal therapy	$76	$193
PERIODONTIC SERVICES			
D4210	Gingivectomy or gingivoplasty – 4 or more teeth, per quadrant	$107	$269
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth, per quadrant	$33	$86
D4240	Gingival flap procedure, including root planing – 4 or more contiguous teeth	$132	$333
D4241	Gingival flap procedure, including root planing – 1 to 3 teeth, per quadrant	$67	$167
D4249	Clinical crown lengthening – hard tissue	$146	$370
D4260	Osseous (bone) surgery – 4 or more teeth, per quadrant	$208	$536
D4261	Osseous (bone) surgery – 1 to 3 teeth, per quadrant	$105	$269
D4263	Bone replacement graft – first site in quadrant	$140	$241
D4264	Bone replacement graft – each additional site in quadrant	$70	$121
D4265	Biologic material to aid in soft/osseous tissue	$70	$122
D4268	Surgical revision procedure – per tooth	$132	$338

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D4270	Pedicle soft tissue graft procedure	$140	$360
D4275	Soft tissue allograft	$165	$419
D4276	Combined connective tissue and double pedicle	$140	$360
D4277	Free soft tissue graft – per tooth	$143	$317
D4278	Free soft tissue graft – each additional tooth	$71	$51
D4320	Provisional splinting – intracoronal	$44	$119
D4321	Provisional splinting – extracoronal	$44	$119
D4341	Perio scaling and root planing – 4 or more teeth, per quadrant	$44	$119
D4342	Perio scaling and root planing – 1 to 3 teeth, per quadrant	$22	$60
D4355	Full mouth debridement	$43	$108
D4910	Periodontal maintenance	$23	$62
PROSTHETICS (REMOVABLE)			
D5110	Complete denture – maxillary	$456	$290
D5120	Complete denture – mandibular	$456	$290
D5130	Immediate denture – maxillary	$492	$317
D5140	Immediate denture – mandibular	$492	$317
D5211	Maxillary partial denture – resin base (incl. any conventional clasps, rests and teeth)	$404	$258
D5212	Mandibular partial denture – resin base (incl. any conventional clasps, rests and teeth)	$404	$258
D5213	Maxillary partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	$499	$317
D5214	Mandibular partial denture – cast metal framework with resin denture bases (incl. any conventional clasps, rests and teeth)	$499	$317
D5221	Immediate maxillary partial denture	$404	$258
D5222	Immediate mandibular partial denture	$404	$258
D5223	Immediate maxillary partial denture	$499	$317
D5224	Immediate mandibular partial denture	$499	$317
D5225	Maxillary partial denture	$499	$317
D5226	Mandibular partial denture	$499	$317

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D5281	Removable unilateral partial denture – piece cast metal (incl. clasps and teeth)	$272	$172
D5410	Adjust complete denture – maxillary	$22	$16
D5411	Adjust complete denture – mandibular	$22	$16
D5421	Adjust partial denture – maxillary	$22	$16
D5422	Adjust partial denture – mandibular	$22	$16
D5510	Repair broken complete denture base	$51	$34
D5520	Replace missing/broken teeth – per tooth	$41	$27
D5610	Repair resin denture base	$49	$31
D5620	Repair cast framework	$60	$38
D5630	Repair or replace broken clasp	$57	$37
D5640	Replace broken teeth – per tooth	$43	$28
D5650	Add tooth to existing partial denture	$55	$35
D5660	Add clasp to existing partial denture	$63	$43
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$242	$155
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$242	$155
D5710	Rebase complete maxillary denture	$170	$108
D5711	Rebase complete mandibular denture	$170	$108
D5720	Rebase maxillary partial denture	$170	$108
D5721	Rebase mandibular partial denture	$170	$108
D5730	Reline complete maxillary denture (chairside)	$101	$65
D5731	Reline complete mandibular denture (chairside)	$101	$65
D5740	Reline maxillary partial denture (chairside)	$101	$65
D5741	Reline mandibular partial denture (chairside)	$101	$65
D5750	Reline complete maxillary denture (lab)	$140	$86
D5751	Reline complete mandibular denture (lab)	$140	$86
D5760	Reline maxillary partial denture (lab)	$140	$86
D5761	Reline mandibular partial denture (lab)	$140	$86
D5820	Interim partial denture – maxillary	$175	$113
D5821	Interim partial denture – mandibular	$175	$113

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D5850	Tissue conditioning – maxillary	$49	$33
D5851	Tissue conditioning – mandibular	$45	$31
PROSTHETICS (FIXED)*			
D6205	Pontic – indirect resin based composite	$159	$102
D6210	Pontic – cast high noble metal	$411	$263
D6211	Pontic – cast predominantly base metal	$378	$226
D6212	Pontic – cast noble metal	$365	$231
D6214	Pontic – titanium	$411	$263
D6240	Pontic – porcelain fused to high noble metal	$418	$269
D6241	Pontic – porcelain fused to predominantly base metal	$365	$231
D6242	Pontic – porcelain fused to noble metal	$397	$252
D6545	Retainer – cast metal for resin bonded fixed	$159	$102
D6602	Inlay – cast high noble metal – 2 surfaces	$319	$208
D6603	Inlay – cast high noble metal – 3 or more surfaces	$382	$242
D6604	Inlay – cast predominantly base metal – 2 surfaces	$319	$208
D6605	Inlay – cast predominantly base metal – 3 or more surfaces	$330	$210
D6606	Inlay – cast noble metal – 2 surfaces	$291	$188
D6607	Inlay – cast noble metal – 3 or more surfaces	$348	$220
D6610	Onlay – cast high noble metal – 2 surfaces	$372	$162
D6611	Onlay – cast high noble metal – 3 or more surfaces	$407	$176
D6612	Onlay – cast predominantly base metal – 2 surfaces	$320	$138
D6613	Onlay – cast predominantly base metal – 3 or more surfaces	$355	$153
D6614	Onlay – cast noble metal – 2 surfaces	$337	$146
D6615	Onlay–cast noble metal – 3 or more surfaces	$372	$162
D6624	Inlay – titanium	$382	$242
D6634	Onlay – titanium	$407	$176
D6710	Crown – indirect resin based composite	$159	$102
D6750	Crown – porcelain fused to high noble metal	$428	$274
D6751	Crown – porcelain fused to predominantly base metal	$378	$241

*All copayments exclude the cost of noble and precious metals. An additional copayment will be charged if these materials are used.

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D6752	Crown – porcelain fused to noble metal	$404	$258
D6780	Crown – 3/4 cast high noble metal	$397	$247
D6781	Crown – 3/4 cast predominantly base metal	$397	$247
D6782	Crown – 3/4 cast noble metal	$397	$247
D6790	Crown – full cast high noble metal	$418	$269
D6791	Crown – full cast predominantly base metal	$373	$241
D6792	Crown – full cast noble metal	$397	$252
D6794	Crown – titanium	$410	$269
D6930	Recement fixed partial denture	$41	$27
ORAL SURGERY			
D7111	Coronal remnants – deciduous tooth	$11	$24
D7140	Extraction, erupted tooth or exposed root	$19	$47
D7210	Surgical removal of erupted tooth	$44	$108
D7220	Removal of impacted tooth – soft tissue	$50	$134
D7230	Removal of impacted tooth – partially bony	$63	$167
D7240	Removal of impacted tooth – completely bony	$76	$198
D7250	Removal of residual tooth roots	$50	$124
D7260	Oroantral fistula closure	$120	$312
D7261	Primary closure of a sinus perforation	$120	$312
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$63	$177
D7280	Surgical access of an unerupted tooth	$101	$263
D7282	Mobiliz. of erupted or malpositioned tooth – aid erupted	$88	$220
D7283	Placement of device	$51	$132
D7285	Biopsy of oral tissue – hard (bone, tooth)	$50	$129
D7286	Biopsy of oral tissue – soft (all others)	$57	$145
D7287	Cytology sample collection	$29	$73
D7288	Brush biopsy – transepithelial sample collection	$29	$73
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$14	$37

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$50	$129
D7311	Alveoloplasty in conjunction with extractions	$24	$65
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$69	$177
D7321	Alveoloplasty not in conjunction with extractions	$35	$89
D7410	Excision of benign lesion <= 1.25 cm	$69	$172
D7411	Excision of benign lesion > 1.25 cm	$107	$279
D7412	Excision of benign lesion, complicated	$118	$306
D7450	Removal of benign odon cyst/tumor – diam <=1.25cm	$63	$162
D7451	Removal of benign odon cyst/tumor – diam > 1.25cm	$113	$295
D7460	Removal of benign nonodon cyst/tumor – diam <=1.25cm	$69	$177
D7461	Removal of benign nonodon cyst/tumor – diam > 1.25cm	$132	$333
D7471	Removal of lateral exostosis	$101	$263
D7472	Removal of torus palatinus	$101	$263
D7473	Removal of torus mandibularis	$101	$263
D7485	Surgical reduction of osseous tuberosity	$101	$263
D7510	Incision and drainage of abscess – intraoral soft tissue	$33	$81
D7511	Incision and drainage of abscess – intraoral	$40	$101
D7520	Incision/drainage of abscess – extra. soft tissue	$50	$124
D7521	Incision and drainage of abscess	$63	$155
D7530	Foreign body removal from muc./skin/subcut. tissue	$38	$97
D7550	Partial ostect/sequestrect non-vital bone removal	$50	$247
D7910	Suture of recent small wounds up to 5 cm	$18	$45
D7911	Complicated suture – up to 5 cm	$33	$76
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$82	$215
D7963	Frenuloplasty	$81	$215
D7970	Excision of hyperplastic tissue – per arch	$57	$145
D7971	Excision of pericoronal gingiva	$33	$81
D7972	Surgical reduction of fibrous tuberosity	$57	$145

ADA CODE	BENEFIT	YOU PAY IN-PLAN TO DENTIST	YOU ARE REIMBURSED OUT-OF-PLAN
	ORTHODONTICS		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,224	N/B
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,224	N/B
D8670	Periodic orthodontic treatment visit (as part of contract)	$0	N/B
	ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$13	$30
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0	$0
D9223	Deep sedation/general anesthesia – each 15 min. incr.	$33	$87
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$7	$22
D9243	Intravenous moderate sedation/analgesia – each 15 min. incr.	$27	$71
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$15	$48
D9440	Office visit – after regularly scheduled hours	$30	N/B
D9910	Application of desensitizing medication	$5	$17
D9940	Occlusal guard, by report	$82	$283
D9942	Repair and/or reline of occlusal guard	$24	$86
D9951	Occlusal adjustment – limited	$16	$61
D9952	Occlusal adjustment – complete	$62	$252
D9986	Missed appointment	$50	$50

Only current ADA CDT codes are considered valid by Dominion National.

Current Dental Terminology © American Dental Association.

EXCLUSIONS AND LIMITATIONS

Exclusions

The following services are not covered under this plan:

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 Member by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
3. Services which are not necessary for the patient's dental health as determined by the Plan.
4. Cosmetic, elective, or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
5. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in the *Evidence of Coverage*.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan that is described in the *Evidence of Coverage*.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Services that cannot be performed because of the general health of the patient.
11. Implantation and related restorative procedures.
12. Procedures not listed as a Covered benefit under this Plan.
13. Services related to the treatment of TMD (Temporomandibular disorder).
14. Elective surgery including, but not limited to extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
16. Dental expenses incurred prior to your effective date of coverage.
17. Treatment of malignancies, neoplasm or congenital malformations, except as may be otherwise covered in your medical plan as described in the *Evidence of Coverage*.
18. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan which is described in the *Evidence of Coverage*.
19. Experimental procedures, implantations, or pharmacological regimens.
20. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Charges for second opinions, unless pre-authorized.
22. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
23. Occlusal guards, except for the purpose of controlling habitual grinding.

Maryland and DC Only:

Services that cannot be performed because of the general health of the patient.

Limitations

Covered dental services are subject to the following limitations:

1. Replacement of a bridge, crown, or denture within five years after the date it was originally installed.
2. Replacement of filling within two years after original date of placement.
3. Two teeth cleanings and fluoride applications are covered per calendar year.
4. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
5. One set of full mouth X-rays or panoramic film is limited to one set every three years.
6. Retreatment of root canal within two years of the original treatment.
7. Coverage for periodontal surgery of any type, including any associated material is covered once every 36 months per quadrant or surgical site.
8. Coverage for root planing or scaling is limited to once every 24 months per quadrant.
9. Full mouth debridement is covered once per lifetime.
10. Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
11. Coverage for relining of dentures is limited to once every 12 months.
12. 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.
13. Coverage for sealants is limited to the first and second permanent molars for children under the age of 16 once every 24 months.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number provided below.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
TTY	711

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc (Kaiser Health Plan) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. El Kaiser Health Plan no excluye a las personas o las trata de forma diferente por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. Recuerde también:

- Nosotros les brindamos ayuda y servicios sin costo alguno a las personas que tienen una discapacidad que les impide comunicarse con nosotros en forma eficaz, tales como:
  - Intérpretes calificados de lenguaje de señas
  - Información por escrito en otros formatos, tales como letra grande, audio y otros formatos electrónicos accesibles
- Brindamos servicios de idiomas sin costo alguno a personas cuyo idioma principal no sea el inglés, tales como:
  - Intérpretes calificados
  - Información por escrito en otros idiomas

Si necesita dichos servicios, llame al número proporcionado a continuación.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
Línea TTY	711

Si cree que el Kaiser Health Plan no le ha brindado dichos servicios o ha incurrido en discriminación en contra suya de otra manera por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo, usted puede presentar una queja ante el Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, número de teléfono: 1-800-777-7902. Puede presentar una queja por correo o por teléfono. Si necesita ayuda para presentar una queja, el Kaiser Civil Rights Coordinator está disponible para ayudarle. También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services), la Oficina de Derechos Civiles (Office for Civil Rights) a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo electrónico o por teléfono: Departamento de Salud y Servicios Humanos de los Estados Unidos, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሰር ፐርማነንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի միջոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործողություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé ɖé nì mìɔ̀ùn nìín ɓíɖí-wùɖù mú pídyi. Ɔ jǔ ké m̀ dyi dyi-diè-ɖɛ̀ ɓě ɓéɖé ɓá nì céè-ɖɛ̀ m̀ tò ɓó ɖɛ zɔ̀ jè dyíɛ ní, mɔɔ jǔ ɓá nì kũ̀ùn kpɔ̃ jè dyí dyìin ɖé Kaiser Permanente múɛ ní, mɔɔ ɔ dyi ɓɔ̃̌ ɖò jǔ ɓɛ́ m̀ ké ɖɛ ɖò nyu ɓó wé jɛ́ɛ́ ɖò kɔ̃ nì, nìí, ɖá nɔ̀ɓà ɓɛ́ wa tòà ɓó nì ɓóɖóɔ̀ mɔɔ nì gbɛ̆ɛ̀ɔ̀ bìì ɛ, ké nì mu nyɔ-wuɖuún-zà-nyɔ̀ ɖò gbo wùɖùùn.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

State / Region	Phone
California	**1-800-464-4000**
Colorado	**1-800-632-9700**
District of Columbia	**1-800-777-7902**
Georgia	**1-888-865-5813**
Hawaii	**1-800-966-5955**
Maryland	**1-800-777-7902**
Oregon	**1-800-813-2000**
Virginia	**1-800-777-7902**
Washington	**1-800-813-2000**
TTY	**711**

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch fofor, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઇ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમા તમને કોઈચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu palapala noi ʻinikua ola kino a i ʻole i kōkua maʻō ka polokalamu kōkua ola kino Kaiser Permanente, a i ʻole inā ke haʻi nei paha kēia leka nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa ma kēia leka nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnub tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị iji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំ ឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិននេះគឺជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋ ឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조취를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຍຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōļ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeļọk wōņāān. Ñe ewōr aṃ kajjitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjeļā in ej aikuj bwe kwōn ṃakūtkūt ṃokta jān juon raan eo eṃōj an kallikkar, kaļọk nōṃba eo ej leļọk ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníłáágóó éí bee náhaz'ą́. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinilaa, éí bína'ídíłkid doogo, éí doodago díí naaltsoos haa'ída yoołkáałgo hait'áoda í'dííłííł niłníigo éí nitsaa hahoodzojí éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bił ahił hodííłnih.

नेपाली (Nepali): तपाईंसगं कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईँसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईँले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईँको राज्य वा क्षेत्रका लागि दिइएको नम्वरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سؤالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸ਼ੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou ʻaia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesootaʻi i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitang ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): ʻOku ʻia ho totonu ke ke maʻu ha fakatonulea taʻetotongi. Kapau ʻoku ʻi ai haʻo fehuʻi ki ho tohi kole naʻe fakafonu ki he maluʻi ʻinisiua ʻa e Kaiser Permanente, pea kapau ko e tohini ʻoku fiemaʻu keke fai ha meʻa ki ai pe ko ha ʻaho naʻe tuku pau atu ke fai ia, taa ki he fika kuo ʻoatu ki ho siteiti pe ko e vahefonua ʻoku ke ʻi ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اُردو (Urdu): آپ کوکوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí ìrànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbéèrè nípa ìwé tí o kọ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ìfitọnilétí yìí jẹ́ èyí o nílò láti ìgbésẹ̀ kan ní ọjọ́ kan patọ́, pé nọ́mbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òǹgbifọ̀ kan sọ̀rọ̀.

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