

COACHELLA VALLEY

EFFECTIVE JANUARY 2005

Dental Plans and Rates

2005 SMALL BUSINESS

Group Dental Insurance Plans - Fee for Service

Coachella Valley
Effective 1/1/05

	Plan C	Plan D	Plan E	Plan E with Ortho*	Limitations
Service	Plan Pays ¹	Plan Pays ¹	Plan Pays ¹	Plan Pays ¹	
No deductible applies to these procedures					
Exam	100%	100%	100%	100%	Twice in a calendar year
Bitewing X-rays	100%	100%	100%	100%	One set of four films per calendar year
Other X-rays	80%	80%	80%	80%	Full-mouth, single X-rays, and panoramic X-rays once in any 5-year period
Prophylaxis	100%	100%	100%	100%	Twice in a calendar year
Fluoride treatments	100%	100%	100%	100%	Only for children up to age 19 twice in a calendar year
Deductibles apply to these procedures under plans D, E, and E with Orthodontics					
Palliative care	80%	80%	80%	80%	Usual, Customary, and Reasonable
Denture relines	Not covered	80%	80%	80%	Twice in a calendar year (limited to two upper, two lower or any combination)**
Space maintainers	100%	100%	100%	100%	Usual, Customary, and Reasonable
Fillings	80%	80%	80%	80%	Usual, Customary, and Reasonable
Stainless steel crowns	80%	80%	80%	80%	Primary teeth only
Endodontics	Not covered	80%	80%	80%	Usual, Customary, and Reasonable
Periodontics	Not covered	80%	80%	80%	Usual, Customary, and Reasonable
Oral surgery	Not covered	80%	80%	80%	Usual, Customary, and Reasonable
Crowns and cast restorations	Not covered	Not covered	50%	50%	Includes replacements after 5 years, but only if originally covered by KPIC dental plan
Prosthodontics	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after 5 years, but only if originally covered by KPIC dental plan)
Orthodontics	Not covered	Not covered	Not covered	50%	For eligible dependent children, \$1,500 lifetime maximum per insured (replacement or repair of an orthodontic appliance paid for in part or in full by this plan is not covered)
Deductible	No deductible	\$25	\$25	\$25	Per person per calendar year up to a family maximum of \$75 per calendar year
Maximum	\$500	\$1,000	\$1,000	\$1,000	Per person per calendar year
Monthly Premiums					
	Plan C	Plan D	Plan E	Plan E with Ortho	
Employee	\$26.32	\$37.21	\$50.62	\$51.69	
Employee + Spouse	\$53.96	\$76.28	\$103.77	\$105.96	
Employee + Child(ren)	\$55.28	\$78.14	\$106.30	\$108.54	
Family	\$87.39	\$123.53	\$168.06	\$171.60	

* Plan E with Ortho requires at least 25 subscribers.

** Limitation applies only to Plan D.

¹ Benefits payable will be based on the lesser of the Usual, Customary, and Reasonable fees or the fees actually charged.

Group Dental Insurance Plans - PPO

Coachella Valley
Effective 1/1/05

Plan D PPO 1500		Plan E PPO 1000		Plan E PPO 1500		Limitations
PPO Network Plan Pays ²	Out-of-Network Plan Pays	PPO Network Plan Pays ²	Out-of-Network Plan Pays	PPO Network Plan Pays ²	Out-of-Network Plan Pays	
No deductible applies to these procedures						
100%	50%	100%	50%	100%	50%	Twice in a calendar year
100%	50%	100%	50%	100%	50%	Twice in a calendar year for children to age 18 or once in a calendar year for adults age 18 and over
80%	50%	80%	50%	80%	50%	Full-mouth, single X-rays, and panoramic X-rays once in any 5-year period
100%	50%	100%	50%	100%	50%	Twice in a calendar year
100%	50%	100%	50%	100%	50%	Only for children up to age 19, twice in a calendar year
80%	50%	80%	50%	80%	50%	
80%	50%	80%	50%	80%	50%	Twice in a calendar year
100%	50%	100%	50%	100%	50%	
80%	50%	80%	50%	80%	50%	
80%	50%	80%	50%	80%	50%	Primary teeth only
80%	50%	80%	50%	80%	50%	
80%	50%	80%	50%	80%	50%	
80%	50%	80%	50%	80%	50%	
Not covered	Not covered	50%	50%	50%	50%	Includes one replacement in any 5-year period, but only if originally covered by KPIC dental plan
Not covered	Not covered	50%	50%	50%	50%	Standard removable prosthetic appliances (includes one replacement in any 5-year period, but only if originally covered by KPIC dental plan)
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
\$25	\$50	\$25	\$50	\$25	\$50	Per person, per calendar year up to a family maximum of \$75 and \$150—under In and Out of Network, respectively
\$1,500	\$1,500	\$1,000	\$1,000	\$1,500	\$1,500	Per person, per calendar year
Plan D PPO 1500		Plan E PPO 1000		Plan E PPO 1500		
\$29.89		\$36.45		\$38.27		
\$61.27		\$74.72		\$78.45		
\$62.77		\$76.54		\$80.37		
\$99.23		\$121.01		\$127.05		

² Benefits payable will be based on the Maximum Allowable Charge.

Important Information

The following services are not covered under any of the Kaiser Permanente Insurance Company (KPIC) group dental insurance plans:

- Any treatment or procedure not listed as covered.
- Charges in excess of the Maximum Allowable Charge.
- Services for injuries or conditions covered under workers' compensation or employer's liability laws.
- Cosmetic surgery, dentistry, or services to correct hereditary, congenital, or developmental malformations.
- Restoration of tooth structure or chewing surfaces for damages due to wear.
- Prosthodontic services or procedures started prior to a person's date of eligibility.
- Prescribed drugs, premedication, or pain relievers.
- Experimental procedures.
- Hospital costs or extra charges for hospital treatment.
- Anesthesia (except for general anesthesia for oral surgery).
- Extra-oral grafts, implants, and implant removal.
- Treatment related to the temporomandibular joint (TMJ).
- Plaque control programs, oral hygiene, and dietary instructions.
- Orthodontic treatment except for eligible dependent children under Plan E with orthodontics.
- Treatment plans that are more expensive than those customarily provided or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
- Pit and fissure sealants, unless for the first molars of children up to age 9 and second molars for children up to age 14. The molar must have no decay and no restoration, and the occlusal surface must be intact. Coverage does not include the repair or replacement of a sealant on any tooth within 3 years of application.
- Services which are provided to the covered person by any federal or state governmental agency or are provided without cost to the covered person by any municipality, county, or other political subdivision, except Medi-Cal benefits.
- Charges by any hospital or other surgical treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants.
- Replacement of existing restoration for any purposes other than active tooth decay.
- Intravenous sedation, occlusal guards, and complete occlusal adjustment.
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
- Hypnosis.
- Charges for completion of forms.
- Charges for speech therapy.
- Charges for lost or stolen appliances.
- Services for which no charge is normally made in the absence of insurance.

Predetermination of benefits is recommended for services in excess of \$300. This document is not intended as a summary plan description, nor is it designed to serve as the *Certificate of Insurance*. It contains only a summary of the benefits, exclusions, and limitations. If you have specific questions regarding benefit structure, limitations, or exclusions, consult the *Certificate of Insurance* or contact Delta Dental's Customer Service Department. This dental insurance plan is underwritten by Kaiser Permanente Insurance Company and administered by Delta Dental of California. For questions regarding your dental benefits, limitations, or exclusions, see your *Certificate of Insurance* or call Delta Dental's Customer Service Department at 1-888-335-8227, 8:00 a.m. - 5:00 p.m., Monday through Friday.



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