

# Group Dental Insurance Plans - Fee for Service

Southern California\*  
Effective 7/1/05–12/1/05

# Group Dental Insurance Plans - PPO

Southern California\*  
Effective 7/1/05–12/1/05

| Service  | Plan C                 | Plan D                 | Plan E                 | Plan E with Ortho**      | Limitations   | Plan D PPO 1500  |                          | Plan E PPO 1000                    |                          | Plan E PPO 1500                    |                          | Limitations  |
|--|------------------------|------------------------|------------------------|--------------------------|---|--|--------------------------|------------------------------------|--------------------------|------------------------------------|--------------------------|--|
|  | Plan Pays <sup>1</sup> | Plan Pays <sup>1</sup> | Plan Pays <sup>1</sup> | Plan Pays <sup>1</sup>   |   | PPO Network Plan Pays <sup>2</sup>   | Out-of-Network Plan Pays | PPO Network Plan Pays <sup>2</sup> | Out-of-Network Plan Pays | PPO Network Plan Pays <sup>2</sup> | Out-of-Network Plan Pays |  |
| <b>No deductible applies to these procedures</b>                                       |                        |                        |                        |                          |   | <b>No deductible applies to these procedures</b>                                       |                          |                                    |                          |                                    |                          |  |
| Exam   | 100%                   | 100%                   | 100%                   | 100%                     | Twice in a calendar year  | 100%   | 50%                      | 100%                               | 50%                      | 100%                               | 50%                      | Twice in a calendar year   |
| Bitewing X-rays  | 100%                   | 100%                   | 100%                   | 100%                     | One set of four films per 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  |
| Other X-rays   | 80%                    | 80%                    | 80%                    | 80%                      | Full-mouth, single X-rays, and panoramic X-rays once in any 5-year period   | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      | 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  | 100%   | 50%                      | 100%                               | 50%                      | 100%                               | 50%                      | Twice in a calendar year   |
| Fluoride treatments  | 100%                   | 100%                   | 100%                   | 100%                     | Only for children up to age 19 twice in a calendar year   | 100%   | 50%                      | 100%                               | 50%                      | 100%                               | 50%                      | Only for children up to age 19, twice in a calendar year   |
| <b>Deductibles apply to these procedures under plans D, E, and E with Orthodontics</b> |                        |                        |                        |                          |   | <b>Deductibles apply to these procedures under plans D, E, and E with Orthodontics</b> |                          |                                    |                          |                                    |                          |  |
| Palliative care  | 80%                    | 80%                    | 80%                    | 80%                      | Usual, Customary, and Reasonable  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      |  |
| Denture relines  | Not covered            | 80%                    | 80%                    | 80%                      | Twice in a calendar year (limited to two upper, two lower or any combination)**   | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      | Twice in a calendar year   |
| Space maintainers  | 100%                   | 100%                   | 100%                   | 100%                     | Usual, Customary, and Reasonable  | 100%   | 50%                      | 100%                               | 50%                      | 100%                               | 50%                      |  |
| Fillings   | 80%                    | 80%                    | 80%                    | 80%                      | Usual, Customary, and Reasonable  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      |  |
| Stainless steel crowns   | 80%                    | 80%                    | 80%                    | 80%                      | Primary teeth only  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      | Primary teeth only   |
| Endodontics  | Not covered            | 80%                    | 80%                    | 80%                      | Usual, Customary, and Reasonable  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      |  |
| Periodontics   | Not covered            | 80%                    | 80%                    | 80%                      | Usual, Customary, and Reasonable  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      |  |
| Oral surgery   | Not covered            | 80%                    | 80%                    | 80%                      | Usual, Customary, and Reasonable  | 80%  | 50%                      | 80%                                | 50%                      | 80%                                | 50%                      |  |
| Crowns and cast restorations   | Not covered            | Not covered            | 50%                    | 50%                      | Includes replacements after 5 years, but only if originally covered by KPIC dental plan   | 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  |
| 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)   | 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) |
| 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) | Not covered  | Not covered              | Not covered                        | Not covered              | Not covered                        | Not covered              | Not covered  |
| Deductible   | No deductible          | \$25                   | \$25                   | \$25                     | Per person per calendar year up to a family maximum of \$75 per calendar year   | \$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                             |
| Maximum  | \$500                  | \$1,000                | \$1,000                | \$1,000                  | Per person per calendar year  | \$1,500  | \$1,500                  | \$1,000                            | \$1,000                  | \$1,500                            | \$1,500                  | Per person, per calendar year  |
| <b>Monthly Premiums</b>  | <b>Plan C</b>          | <b>Plan D</b>          | <b>Plan E</b>          | <b>Plan E with Ortho</b> |   | <b>Plan D PPO 1500</b>   |                          | <b>Plan E PPO 1000</b>             |                          | <b>Plan E PPO 1500</b>             |                          |  |
| Employee   | \$25.31                | \$35.78                | \$48.68                | \$49.70                  |   | \$28.74  |                          | \$35.05                            |                          | \$36.80                            |                          |  |
| Employee + Spouse  | \$51.89                | \$73.35                | \$99.79                | \$101.88                 |   | \$58.91  |                          | \$71.85                            |                          | \$75.44                            |                          |  |
| Employee + Child(ren)  | \$53.15                | \$75.13                | \$102.22               | \$104.37                 |   | \$60.35  |                          | \$73.60                            |                          | \$77.28                            |                          |  |
| Family   | \$84.04                | \$118.79               | \$161.61               | \$165.00                 |   | \$95.41  |                          | \$116.36                           |                          | \$122.17                           |                          |  |

\* Includes Los Angeles, Orange, Riverside (excluding Coachella Valley), San Bernardino and Ventura counties.

\*\* Plan E with Ortho requires at least 25 subscribers.

\*\*\* Limitation applies only to Plan D.

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

\* Includes Los Angeles, Orange, Riverside (excluding Coachella Valley), San Bernardino and Ventura counties.

<sup>2</sup> 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 at 1-888-335-8227, 8:00 am - 5:00 pm., Monday through Friday. This dental insurance plan is underwritten by Kaiser Permanente Insurance Company and administered by Delta Dental of California.**

SOUTHERN CALIFORNIA

EFFECTIVE JULY–DECEMBER 2005

# Dental Plans and Rates

2005 SMALL BUSINESS

 KAISER PERMANENTE®