Bay Area

Supplemental family dental plans and rates

For effective dates January 1–December 1, 2023

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Insurance Company (KPIC) Fee-for-Service (Premier) dental plans

Bay Area[1]
For effective dates 1/1/23–12/1/23

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The KPIC Premier plans aren't intended to satisfy the ACA child dental benefits.

	PLAN C	PLAN D	PLAN E	PLAN E WITH ORTHO[2]
SERVICE	**Plan Pays[3]**	**Plan Pays[3]**	**Plan Pays[3]**	**Plan Pays[3]**
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.				
EXAM – Twice a year	100%	100%	100%	100%
BITEWING X-RAYS – Twice a year For children through age 18, or once a year for adults ages 19 and over	100%	100%	100%	100%
OTHER X-RAYS Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period	80%	80%	80%	80%
PROPHYLAXIS (CLEANING) A cleaning twice a year to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%
FLUORIDE Only for children through age 18, twice a year	100%	100%	100%	100%
SPACE MAINTAINERS	100%	100%	100%	100%
DEDUCTIBLES APPLY TO PROCEDURES UNDER PLANS D, E, AND E WITH ORTHODONTICS.				
DEDUCTIBLE Per person, per year, up to a family maximum of $75 per year	No deductible	$25	$25	$25
BENEFIT MAXIMUM The benefit maximum represents the total amount paid by the plan per person, per year	$500	$1,000	$1,000	$1,000
DENTAL IMPLANTS	Not covered	Not covered	Not covered	Not covered
DENTURE RELINES – Twice a year	Not covered	80%	80%	80%
FILLINGS	80%	80%	80%	80%
STAINLESS STEEL CROWNS Primary teeth only	80%	80%	80%	80%
ENDODONTICS A dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%
PERIODONTICS A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%
ORAL SURGERY	Not covered	80%	80%	80%
CROWNS AND CAST RESTORATIONS Includes replacements after five years, but only if originally covered by KPIC dental plan	Not covered	Not covered	50%	50%
PROSTHODONTICS Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)	Not covered	Not covered	50%	50%
ORTHODONTICS For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan isn't covered.)	Not covered	Not covered	Not covered	50%

MONTHLY PREMIUMS	PLAN C	Plan D	Plan E	Plan E Ortho[2]
Employee	$39.03	$60.68	$78.80	$80.45
Employee + spouse	$80.01	$124.39	$161.54	$164.92
Employee + child(ren)	$81.97	$127.42	$165.48	$168.94
Family	$129.58	$201.45	$261.62	$267.09

[1]For the ZIP codes within the Kaiser Permanente service area, dental rate area includes: Alameda (except ZIP codes 95377 and 95391), Contra Costa, Marin, Napa (except ZIP code 95476), Sacramento (only 94571), San Francisco, San Joaquin (only 94514), San Mateo, Santa Clara, Santa Cruz, Solano (except ZIP codes 95616, 95618, and 95690), Sonoma (only ZIP code 94515), and Yolo (only ZIP codes 95607 and 95694) counties.
[2]Plan E with Orthodontics requires at least 10 subscribers.
[3]Benefits payable will be based on the lesser of the prevailing fee or the submitted amount fee.

Kaiser Permanente Insurance Company (KPIC) PPO dental plans

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The KPIC PPO plans aren't intended to satisfy the ACA child dental benefits.

	PPO AG 1500		PPO AH 2000		PPO D 1500		PPO E 1000		PPO E 1500	
SERVICE	Plan Pays[1] (PPO Network)	Plan Pays[1,2] (Out of Network)	Plan Pays[1] (PPO Network)	Plan Pays[1,2] (Out of Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out of Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out of Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out of Network)
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.										
EXAM – Twice a year	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
BITEWING X-RAYS – Twice a year For children through age 18, or once a year for adults ages 19 and over	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
OTHER X-RAYS Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
PROPHYLAXIS (cleaning) A cleaning twice a year to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
FLUORIDE Only for children through age 18, twice a year	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
SPACE MAINTAINERS	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
DEDUCTIBLES APPLY TO PROCEDURES BELOW.										
DEDUCTIBLE	$50	$50	$50	$50	$25	$50	$25	$50	$25	$50
BENEFIT MAXIMUM The benefit maximum represents the total amount paid by the plan per person, per year	$1,500		$2,000		$1,500		$1,000		$1,500	
DENTAL IMPLANTS	Not covered	Not covered	50%	50%	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
DENTURE RELINES – Twice a year	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
FILLINGS	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
STAINLESS STEEL CROWNS - Primary teeth only	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
ENDODONTICS A dental specialty concerned with treatment of the root and nerve of the tooth	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
PERIODONTICS A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
ORAL SURGERY	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
CROWNS AND CAST RESTORATIONS Includes replacements after five years, but only if originally covered by KPIC dental plan	50%	50%	50%	50%	Not covered	Not covered	50%	50%	50%	50%
PROSTHODONTICS Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)	50%	50%	50%	50%	Not covered	Not covered	50%	50%	50%	50%
ORTHODONTICS For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan isn't covered.)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Monthly premiums	**PPO AG 1500**	**PPO AH 2000**	**PPO D 1500**	**PPO E 1000**	**PPO E 1500**
Employee	$64.83	$70.62	$44.32	$54.04	$59.58
Employee + spouse	$132.90	$144.77	$90.86	$110.78	$122.13
Employee +w child(ren)	$136.14	$148.30	$93.07	$113.48	$125.11
Family	$215.24	$234.46	$147.15	$179.41	$197.79

[1]For the ZIP codes within the Kaiser Permanente service area, dental rate area includes: Alameda (except ZIP codes 95377 and 95391), Contra Costa, Marin, Napa (except ZIP code 95476), Sacramento (only 94571), San Francisco, San Joaquin (only 94514), San Mateo, Santa Clara, Santa Cruz, Solano (except ZIP codes 95616, 95618, and 95690), Sonoma (only ZIP code 94515), and Yolo (only ZIP codes 95607 and 95694) counties.
[2]Reimbursement for all dentists will be based on the PPO contracted fee.
[3]Benefits payable will be based on the lesser of the prevailing fee or the submitted amount fee.

Exclusions for the KPIC Fee-for-Service (Premier) and KPIC PPO dental plans

The KPIC Fee-for Service (Premier) and PPO dental insurance plans aren't intended to satisfy the ACA child dental benefits.

The following services aren't covered under any Kaiser Permanente Insurance Company (KPIC) group dental insurance plans:

- Cosmetic surgery, dentistry, or services to correct hereditary, congenital, or developmental malformations.
- Restoration of tooth structure crowns, and/or cast restorations, or chewing surfaces for damages due to wear.
- Prosthodontic services or procedures started prior to a person's date of eligibility.
- Prescribed drugs medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- Anesthesia (except general anesthesia for oral surgery).
- Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis) their removal or other associated procedures. Doesn't apply to the PPO AH 2000
- Treatment related to the temporomandibular joint (TMJ).
- Orthodontic treatment, except for eligible dependent children under Plan E with Orthodontics.
- Treatment plans that are higher level of services than those customarily provided under accepted dental practice or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
- Replacement of existing restoration for any purpose other than active tooth decay.
- Intravenous sedation, occlusal guards, or complete occlusal adjustment.

Predetermination of benefits is recommended for services in excess of $300. This document isn't intended as a summary plan description, nor is it designed to serve as the *Certificate of Insurance* **or the** *Schedule of Coverage***. It contains only a summary of benefits, exclusions, and limitations.**

If you have specific questions regarding benefit structure, limitations, or exclusions, consult the *Certificate of Insurance* **and the** *Schedule of Coverage* **or contact Delta Dental's Customer Service Department at 800-835-2244, 8 a.m. to 5 p.m., Monday through Friday.**

For a list of in-network providers, contact Delta Dental's Customer Service Department or visit deltadentalins.com.

This dental insurance plan is underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California.

DeltaCare HMO Dental plans

DeltaCare USA is underwritten and administered by Delta Dental of California.

Northern California and Southern California
For effective dates 1/1/23–12/1/23

	DELTACARE 10A	DELTACARE 13B
SERVICES	**Member Pays**	**Member Pays**
PREVENTIVE CARE – Twice a year Periodic and comprehensive – oral evaluation	No cost	No cost
Bitewing X-rays - Twice a year For children through age 18, or once a year for adults ages 19 and over	No cost	No cost
Prophylaxis – Twice a year	No cost	No cost
Fluoride treatments Only for children up to age 19, twice a year	No cost	No cost
Space maintainers Removable – unilateral	$10	$50
PERIODONTICS – Twice a year Maintenance	No cost	$35
Scaling and root planing Limited to four quadrants per year	No cost	$50
Surgery – osseous (includes flap entry and closure) Four or more teeth per quadrant	$175	$300
RESTORATIVE – Four or more surfaces Fillings – primary or permanent amalgam	No cost	No cost
Composite crowns – resin-based Anterior	No cost	$55
Crown – porcelain	$195	$355
Inlay – metallic 1 surface	No cost	$145
ENDODONTICS Therapeutic pulpotomy Excludes final restoration	No cost	$25
Root amputation – Per root	No cost	$70
Root canal – anterior Excludes final restoration	$45	$95
Root canal – molar Excludes final restoration	$205	$335
PROSTHODONTICS – Complete denture The enrollee must continue to be eligible, and the service must be provided at the contract dentist facility where the denture was originally delivered.	$100	$285
Reline maxillary or mandibular denture – chairside Complete or partial	No cost	$50
Reline maxillary or mandibular denture – laboratory Complete or partial	$35	$85
ORAL AND MAXILLOFACIAL SURGERY Extraction – erupted tooth or exposed root Elevation and/or forceps removal	No cost	$5
Surgical removal of erupted tooth Complete or partial	$15	$45
ORTHODONTICS Comprehensive orthodontic Child or adolescent to age 19	$1,700	$1,900
Comprehensive orthodontic Adults, including covered dependent adult children	$1,900	$2,100
Monthly premium rates for Southern California		
Employee	$20.51	$14.56
Employee + spouse	$39.17	$27.81
Employee + child(ren)	$54.56	$38.73
Family	$75.27	$53.44
Monthly premium rates for Northern California		
Employee	$23.71	$17.36
Employee + spouse	$45.29	$33.16
Employee + child(ren)	$63.07	$46.18
Family	$87.02	$63.71

Benefits listed above are only a sample of provided services and associated costs. Costs will vary. Please see your *Evidence of Coverage* for a comprehensive list of all services and costs. DeltaCare benefits are covered only when performed by an in-network California DeltaCare HMO provider. In California, DeltaCare USA is underwritten and administered by Delta Dental of California. The DeltaCare HMO plans aren't intended to satisfy the ACA child dental benefits.

Exclusions of benefits for the DeltaCare HMO dental plans

The DeltaCare HMO plans aren't intended to satisfy the ACA child dental benefits.

- The DeltaCare HMO dental plan isn't available for employees enrolled in a PPO medical plan and living outside of California.
- Any procedure that in the professional opinion of the contract dentist:
  - has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - is inconsistent with generally accepted standards for dentistry.
- Services solely for cosmetic purposes, with the exception of procedure D9972 (external bleaching, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
- Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns, and fixed partial dentures (bridges) for children under 16 years of age.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, and fixed partial dentures (bridges).
- Procedures, appliances, or restoration, if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith), and personalization and characterization of complete and partial dentures.
- Implant-supported dental appliances and attachments; implant placement, maintenance, or removal; and all other services associated with a dental implant.
- Consultations for noncovered benefits.
- Dental services received from any dental facility other than the assigned contract dentist, a preauthorized dental specialist, or a contract orthodontist except for Emergency Services as described in the contract and/or *Evidence of Coverage*.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
- Prescription drugs.
- Dental expenses incurred in connection with any dental or orthodontic procedure started before the enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken, and orthodontics unless qualified for the orthodontic treatment in progress provision.
- Lost, stolen, or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by accident of any kind.
- Myofunctional and parafunctional appliances and/or therapies.
- Composite or ceramic brackets, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.

For additional benefit information or a directory of Delta dentists, please call Delta Dental at **800-422-4234** or visit **deltadentalins.com**.

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