Kaiser Permanente Insurance Company (KPIC)
Group Dental Insurance Plan

DELTA DENTAL®

FFS Benefits Comparison – California						
Service	Plan C	Plan D	Plan E	Plan E w/Ortho	Plan G	Limitations
	Plan pays[1]					
Deductible not applicable to these procedures						
Exam	100%	100%	100%	100%	100%	Twice in a calendar year
Bitewing X-rays	100%	100%	100%	100%	100%	Twice in a calendar year for children through age 18, or once in a calendar year for adults 19 and over
Other X-rays	80%	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any 5-year period
Prophylaxis	100%	100%	100%	100%	100%	Twice in a calendar year
Fluoride treatments	100%	100%	100%	100%	100%	Only for children up to age 19, twice in a calendar year
Deductible applies to these procedures under Plans D, E, E with Ortho, and G						
Palliative care	80%	80%	80%	80%	80%	Usual, Customary, and Reasonable
Denture relines	Not covered	80%	80%	80%	80%	Twice in a calendar year (limited to 2 upper, 2 lower, or any combination)[2]
Space maintainers	100%	100%	100%	100%	100%	Usual, Customary, and Reasonable
Fillings	80%	80%	80%	80%	80%	Usual, Customary, and Reasonable
Stainless steel crowns	80%	80%	80%	80%	80%	Primary teeth only
Endodontics	Not covered	80%	80%	80%	80%	Usual, Customary, and Reasonable
Periodontics	Not covered	80%	80%	80%	80%	Usual, Customary, and Reasonable
Oral surgery	Not covered	80%	80%	80%	80%	Usual, Customary, and Reasonable
Crowns and cast restorations	Not covered	Not covered	50%	50%	50%	Includes replacements in 5 years, but only if originally covered by KPIC dental plan
Prosthodontics	Not covered	Not covered	50%	50%	50%	Standard removable prosthetic appliances (includes replacements after 5 years, but only if originally covered by KPIC dental plan)
Orthodontics	Not covered	Not covered	Not covered	50%	Not covered	For eligible dependent children, $1,500 lifetime maximum per insured (replacement or repair of an orthodontic appliance is not covered)[3]
Deductible	No deductible	$25	$25	$25	$50	Per person, per calendar year, up to a family maximum of $75 per calendar year ($150 family maximum for Plan G)
Maximum	$500	$1,000	$1,000	$1,000	$1,500	Per person, per calendar year

[1] Benefits payable will be based on the lesser of the Usual, Customary, and Reasonable fees or the fees actually charged.
[2] Limitation applies only to Plan D.
[3] Applies to Plan E with Ortho only.

For rates on KPIC group dental insurance plans, please contact your Kaiser Permanente representative or broker.
All rate quotes will be provided by Kaiser Foundation Health Plan, Inc., Underwriting Department.

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The following services are not covered under any of the 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 and within the PPO network.
- 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.
- 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, unless this exclusion is prohibited by law.
- 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 speech therapy.
- Charges for lost or stolen appliances.
- Services for which no charge is normally made in the absence of insurance.
- Any single procedure provided prior to the date the enrollee became eligible for services under this dental plan.

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* or *Schedule of Coverage*. 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* and *Schedule of Coverage*, 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 additional benefit information and a directory of Delta Dental dentists, please call toll free at **800-835-2244.** Also, you may search for providers through Delta Dental's website: **deltadentalins.com**.

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