

COACHELLA VALLEY

EFFECTIVE JANUARY–JUNE 2010

# Dental plans and rates

## 2010 SMALL BUSINESS

# Delta Dental Premier

Coachella Valley  
Effective 1/1/10–6/1/10

	Plan C	Plan D	Plan E	Plan E with Ortho <sup>1</sup>	Limitations
<b>Service</b>	<b>Plan pays<sup>2</sup></b>	<b>Plan pays<sup>2</sup></b>	<b>Plan pays<sup>2</sup></b>	<b>Plan pays<sup>2</sup></b>	
<b>No deductible applies to these procedures.</b>					
<b>Exam</b>	100%	100%	100%	100%	Twice in a calendar year
<b>Bitewing X-rays</b> <small>X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings</small>	100%	100%	100%	100%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
<b>Other X-rays</b>	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panoramic X-rays once in any five-year period
<b>Prophylaxis</b> <small>a professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease</small>	100%	100%	100%	100%	Twice in a calendar year
<b>Fluoride treatments</b> <small>a treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay</small>	100%	100%	100%	100%	Only for children through age 18, twice in a calendar year
<b>Deductibles apply to procedures under plans D, E, and E with Orthodontics.</b>					
<b>Calendar-year deductible</b>	No deductible	\$25	\$25	\$25	Per person per calendar year up to a family maximum of \$75 per calendar year
<b>Annual benefit maximum</b>	\$500	\$1,000	\$1,000	\$1,000	Annual benefit maximum represents the total annual amount paid by the plan
<b>Palliative care</b> <small>any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life</small>	80%	80%	80%	80%	Usual, customary, and reasonable
<b>Denture relines</b>	Not covered	80%	80%	80%	Twice in a calendar year (limited to two upper, two lower, or any combination) <sup>†</sup>
<b>Space maintainers</b>	100%	100%	100%	100%	Usual, customary, and reasonable
<b>Fillings</b>	80%	80%	80%	80%	Usual, customary, and reasonable
<b>Stainless steel crowns</b>	80%	80%	80%	80%	Primary teeth only
<b>Endodontics</b> <small>a dental specialty concerned with treatment of the root and nerve of the tooth</small>	Not covered	80%	80%	80%	Usual, customary, and reasonable
<b>Periodontics</b> <small>a dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth</small>	Not covered	80%	80%	80%	Usual, customary, and reasonable
<b>Oral surgery</b>	Not covered	80%	80%	80%	Usual, customary, and reasonable
<b>Crowns and cast restorations</b> <small>the artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped</small>	Not covered	Not covered	50%	50%	Includes replacements after five years, but only if originally covered by KPIC dental plan
<b>Prostodontics</b> <small>a dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials</small>	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)
<b>Orthodontics</b> <small>a dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery</small>	Not covered	Not covered	Not covered	50%	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 is not covered.)
<b>Monthly premiums</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan E with Ortho<sup>1</sup></b>	
Employee	\$28.19	\$39.85	\$55.84	\$57.02	
Employee + spouse	\$57.79	\$81.69	\$114.48	\$116.89	
Employee + child(ren)	\$59.20	\$83.68	\$117.27	\$119.74	
Family	\$93.59	\$132.30	\$185.40	\$189.30	

<sup>1</sup>Plan E with Orthodontics requires at least 10 subscribers.

<sup>2</sup>Benefits payable will be based on the lesser of the usual, customary, and reasonable fees or the fees actually charged.

# Delta Dental PPO

Coachella Valley  
Effective 1/1/10–6/1/10

## PPO D 1500

## PPO E 1000

## PPO E 1500

## Limitations

<i>PPO network Plan pays<sup>3</sup></i>	<i>Out-of-network Plan pays</i>	<i>PPO network Plan pays<sup>3</sup></i>	<i>Out-of-network Plan pays</i>	<i>PPO network Plan pays<sup>3</sup></i>	<i>Out-of-network Plan pays</i>	
<b>No deductible applies to these procedures.</b>						
100%	50%	100%	50%	100%	50%	Twice in a calendar year
100%	50%	100%	50%	100%	50%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
80%	50%	80%	50%	80%	50%	Full-mouth X-rays, single X-rays, and panoramic X-rays once in any five-year period
100%	50%	100%	50%	100%	50%	Twice in a calendar year
100%	50%	100%	50%	100%	50%	Only for children through age 18, twice in a 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
\$1,500	\$1,500	\$1,000	\$1,000	\$1,500	\$1,500	Annual benefit maximum represents the total annual amount paid by the plan
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 five-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 five-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

## PPO D 1500

## PPO E 1000

## PPO E 1500

\$34.14

\$45.80

\$48.09

\$69.99

\$93.89

\$98.59

\$71.70

\$96.18

\$100.99

\$113.55

\$152.06

\$159.67

<sup>3</sup>Benefits payable will be based on the maximum allowable charge.

<sup>4</sup>Limitation applies only to Plan D.

# Important information for the Delta Dental Premier and Delta Dental PPO dental insurance plans

## The following services are not covered under any 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 general anesthesia for oral surgery)
- Extra-oral grafts, implants, or implant removal
- Treatment related to the temporomandibular joint (TMJ)
- Plaque control programs, oral hygiene, or 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, except for first molars of children through age 8 and second molars for children through age 15. 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 three years of application.
- Services provided to the covered person by any federal or state governmental agency or 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, or 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, or 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* 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 1-888-335-8227, 8 a.m. to 5 p.m., Monday through Friday. For a list of in-network providers, 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.**