NORTH VALLEY

EFFECTIVE JANUARY–DECEMBER 2009

Dental plans and rates

2009 SMALL BUSINESS

KAISER PERMANENTE®

Group dental insurance plans – fee for service

North Valley[1]
Effective 1/1/09–12/1/09

Service	Plan C Plan pays[3]	Plan D Plan pays[3]	Plan E Plan pays[3]	Plan E with Ortho[2] Plan pays[3]	Limitations
No deductible applies to these procedures.					
Exam	100%	100%	100%	100%	Twice in a calendar year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	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
Other X-rays	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis a professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%	Twice in a calendar year
Fluoride treatments a treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	100%	100%	100%	Only for children through age 18, twice in a calendar year
Deductibles apply to procedures under plans D, E, and E with Orthodontics.					
Calendar-year deductible	No deductible	$25	$25	$25	Per person per calendar year up to a family maximum of $75 per calendar year
Annual maximum	$500	$1,000	$1,000	$1,000	Per person per calendar year
Palliative care 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	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)[5]
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 a dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Periodontics a dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Oral surgery	Not covered	80%	80%	80%	Usual, customary, and reasonable
Crowns and cast restorations 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	Not covered	Not covered	50%	50%	Includes replacements after five years, but only if originally covered by KPIC dental plan
Prosthodontics a dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)
Orthodontics a dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	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.)

Monthly premiums	Plan C	Plan D	Plan E	Plan E with Ortho[2]
Employee	$26.35	$40.97	$53.20	$54.32
Employee + spouse	$54.02	$83.98	$109.06	$111.36
Employee + child(ren)	$55.33	$86.03	$111.72	$114.07
Family	$87.48	$136.01	$176.63	$180.35

[1]Includes Amador, El Dorado, Fresno, Kings, Madera, Placer, Sacramento, San Joaquin, Sonoma, Stanislaus, Sutter, Tulare, Yolo (except ZIP codes 95607 and 95694), and Yuba counties
[2]Plan E with Orthodontics requires at least 10 subscribers.
[3]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

North Valley[1]
Effective 1/1/09–12/1/09

PPO D 1500		PPO E 1000		PPO E 1500		Limitations
PPO network Plan pays[4]	*Out-of-network Plan pays*	*PPO network Plan pays*[4]	*Out-of-network Plan pays*	*PPO network Plan pays*[4]	*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 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 panographic 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	Per person per 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 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
$29.92	$36.48	$40.22
$61.33	$74.79	$82.46
$62.83	$76.61	$84.47
$99.32	$121.12	$133.54

[4]Benefits payable will be based on the maximum allowable charge.
[5]Limitation applies only to Plan D.

Important information

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. This dental insurance plan is underwritten by Kaiser Permanente Insurance Company and administered by Delta Dental of California.

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