KAISER PERMANENTE®

DELTA DENTAL®
Delta Dental Plan of California

Kaiser Permanente **Group Dental Plan**

DeltaCare Dental HMO Benefits Plan M57 – California

Service	Member pays	Limitations
Preventive care		
Periodic and comprehensive oral evaluation	No cost	Twice in a calendar year
Bitewing X-rays	No cost	Once in a calendar year for adults age 19 and over
Prophylaxis	$15	Twice in a calendar year
Fluoride treatments	100%	Only for children up to age 19, twice in a calendar year
Space maintainers	100%	Removable—unilateral
Periodontics		
Maintenance	$45	Twice in a calendar year
Scaling and root planing	$55	Limited to four quadrants per calendar year
Surgery—osseous (includes flap entry and closure)	$450	Four or more teeth per quadrant
Restorative		
Fillings—primary or permanent amalgam	$50	Four or more surfaces
Composite crowns—resin-based	$55	Anterior
Crown—porcelain	$300	
Inlay—metallic	$260	One surface

(continues on reverse)

Benefits listed above are a sample of services provided and costs.

Costs will vary; see your **Evidence of Coverage** for a comprehensive list of all services and associated costs.

You must pay a $5 copayment each time you receive dental care in addition to any other cost-sharing listed above.

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(continued from front)

Service	Member pays	Limitations
Endodontics Therapeutic		
pulpotomy	No cost	Excludes final restoration
Root amputation	$75	Per root
Root canal—anterior	$180	Excludes final restoration
Root canal—molar	$375	Excludes final restoration
Prosthodontics		
Complete denture	$395	The enrollee must continue to be eligible and the service must be provided at the contract dentist facility where the denture was originally delivered
Reline maxillary or mandibular denture—chairside	$50	Complete or partial
Reline maxillary or mandibular denture—laboratory	$150	Complete or partial
Oral and maxillofacial surgery		
Extraction	$35	Elevation and/or forceps removal
Surgical removal of erupted tooth	$65	Complete or partial
Orthodontics	Not covered	

Benefits listed above are a sample of services provided and costs.

Costs will vary; see your **Evidence of Coverage** for a comprehensive list of all services and associated costs.

You must pay a $5 copayment each time you receive dental care in addition to any other cost-sharing listed above.

Exclusions of Benefits

The following services are not covered under this plan:

- Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.
- Any procedure that in the professional opinion of the contract dentist
  a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
  b. 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.
- 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, 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.
- Orthodontic services (treatment of malalignment of teeth and / or jaw)
- Myofunctional and parafunctional appliances and/or therapies.

For additional benefit information or a directory of Delta dentists, please call Delta Dental toll free at 1-800-422-4234.