

Dental Health Care Program
for Eligible Employees
and Dependents

**California State University
Enhanced Benefit**

***Combined Evidence of Coverage
and Disclosure Form***

Provided by:



DENTAL
HEALTH PLAN

An Affiliate of Delta Dental of California

12898 Towne Center Drive
Cerritos, CA 90703-8579
(800) 422-4234
www.deltadentalca.org/pmi

EVIDENCE OF COVERAGE DISCLOSURE FORM

DeltaCare Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare Dental Health Care Program ("Program") provided by Private Medical-Care, Inc. ("PMI"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by PMI.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. PLEASE READ THIS EOC CAREFULLY AND COMPLETELY. PERSONS WITH SPECIAL HEALTHCARE NEEDS SHOULD READ THE SECTION ENTITLED "SPECIAL NEEDS".

A STATEMENT DESCRIBING PMI'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The telephone number at which you may obtain information about benefits is (800) 422-4234.

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Definitions

As used in this booklet:

ACUTE CONDITION means a condition requiring Emergency Services while a New Enrollee is within 25 miles from the Facility of the assigned Contract Dentist.

BENEFITS means those dental services available under the terms of the Group Dental Service Contract and described in this booklet.

CONTRACT means the agreement between PMI and California State University.

CONTRACT DENTIST means a Dentist who provides services in general dentistry and who has contracted with PMI to provide Benefits to Enrollees under this Program.

CONTRACT ORTHODONTIST means a Dentist who specializes in orthodontics and who has contracted with PMI to provide Benefits to Enrollees under this Program.

CONTRACT SPECIALIST means a Dentist who provides Specialist Services and has contracted with PMI to provide Benefits to Enrollees under this Program.

COPAYMENT means the fee charged to an Enrollee by a Dentist for the Benefits provided under this Program.

DENTIST means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

DOMESTIC PARTNER means a person who has, together with the Eligible Employee, affirmed a domestic partnership through an Affidavit of Domestic Partnership and meets the eligibility requirements established by the Group.

ELIGIBLE DEPENDENT means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

ELIGIBLE EMPLOYEE means any employee or group member who is eligible for Benefits as described in this booklet.

EMERGENCY SERVICES means only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the patient's health in serious jeopardy.

ENROLLEE means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

GROUP means the employer, union or other organization or group contracting to obtain Benefits.

NEW ENROLLEE means an Enrollee who is enrolled with PMI less than thirty (30) days.

OPEN ENROLLMENT PERIOD means the period preceding the date of commencement of the new plan year in which Eligible Enrollees are allowed to make changes or benefit choices.

OPTIONAL means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the Limitations and Exclusions of this Contract.

SPECIALIST SERVICES means services performed by a Dentist who specializes in the practice of oral surgery, endodontics, pediatric dentistry or periodontics and which must be preauthorized in writing by PMI.

How to use the DeltaCare Program - Choice of Contract Dentist

When you enroll in this Program, you must select one Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished with the enrollment forms. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, PMI will request the selection of another Contract Dentist or assign you to a Contract Dentist. While it is PMI's preference that changes in Contract Dentists be made during Open Enrollment Period only, a transfer to another location will be allowed upon request directed to PMI if you are not satisfied with the dental facility selected or have a change in family status or residence. In order to ensure that your Contract Dentist is notified and PMI eligibility lists are correct, changes in Contract Dentist must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

You will receive a PMI membership packet which advises you of the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services. Simply call your Contract Dentist facility to make an appointment and identify yourself as an Enrollee of PMI. Initial appointments should be scheduled two to three weeks in advance unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of providers should be directed to PMI's Customer Relations department.

EACH ENROLLEE MUST GO TO THE CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR SERVICES PROVIDED BY A SPECIALIST AUTHORIZED IN WRITING BY PMI, OR FOR EMERGENCY SERVICES REQUIRED WHILE 25 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT PROVIDED BY A NON-CONTRACT DENTIST IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's contract with PMI terminates, that Contract Dentist will complete any work in progress, for example: (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in Schedule A, subject to the Limitations and Exclusions described in Schedule B, and in accordance with the Governing Administrative Policies described in Schedule C. The services are performed as needed and deemed necessary by the attending Contract Dentist.

Copayment and Other Charges

Enrollees are required to pay any Copayments listed in Schedule A directly to the Dentist. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice) and charges for visits after normal visiting hours, are listed in Schedule A.

In the event that PMI fails to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by PMI. In the event that PMI fails to pay a non-Contract Dentist, you may be liable to that Dentist for the cost of services.

Provider Compensation

A Contract Dentist is compensated by PMI through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by PMI through an agreed-upon amount for each covered procedure, and by Enrollees through applicable Copayments. **In no event does PMI pay a Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.**

You may obtain further information concerning compensation by calling PMI at the toll-free telephone number shown on the back cover of this booklet.

Emergency Services/Acute Condition

If an Enrollee requires Emergency Services and is more than 25 miles from the facility of the Contract Dentist, then PMI shall reimburse the Enrollee for the cost of such Emergency Services less any applicable Copayment, up to a maximum of \$100.00, per occurrence.

If you have been enrolled with PMI less than 30 days, and if you are currently experiencing an Acute Condition, contact PMI's Customer Relations Department at (800) 422-4234 for authorization for treatment of this condition.

If PMI determines that the circumstances of your Acute Condition require that you obtain treatment from a dentist who is not one of PMI's Contract Dentists, you will be instructed:

- to seek treatment immediately necessary to alleviate severe pain, swelling or bleeding, or immediately necessary to avoid placing your health in serious jeopardy; and
- that treatment for an Acute Condition does not include any services except Emergency Services;
- that PMI will reimburse you for the cost of such treatment up to a maximum of \$100.00, per occurrence; and

- that you must submit a claim within ninety (90) days after receiving the treatment; and
- that you must visit your Contract Dentist for further treatment.

Special Needs

“Special Health Care Need”, means a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are (a) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability, and (b) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

If an Enrollee believes he or she has a Special Health Care Need, the Enrollee should contact PMI's Customer Relations department at (800) 422-4234. PMI will confirm whether such a Special Health Care Need exists, and what arrangements can be made to assist the Enrollee in obtaining such Benefits. PMI shall not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural facility requirements that apply to a Dentist treating persons with Special Health Care Needs.

Dental Facility Accessibility

Many dental facilities provide PMI with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding dental facility accessibility, contact PMI's Customer Relations department at (800) 422-4234.

Relationship With non-Contract Dentists

PMI may require a non-Contract Dentist providing treatment to you of an Acute Condition to agree in writing to meet the same contractual terms and conditions which are imposed upon Dentists who have signed a contract with PMI. PMI is not liable for actions resulting solely from the negligence, malpractice or other tortious or wrongful acts arising out of the treatment provided by a non-Contract Dentist.

Specialist Services

Specialist Services must be referred by a Contract Dentist and authorized in writing by PMI. All approved Specialist Services will be paid by PMI less any applicable Copayments. If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Processing Policies

PMI does not authorize or deny services provided by your Contract Dentist. All Benefits provided by your Contract Dentist are in accordance with Dental Care Guidelines which establish the standard of care to be followed by Contract Dentists. PMI's "processing policies" and the Dental Care Guidelines are reviewed by PMI's Dental Advisory Committee, and updated as needed. You may contact PMI's Customer Relations department at (800) 422-4234 for information regarding PMI's "processing policies" and Dental Care Guidelines.

Claims for Reimbursement

Claims for Emergency Services or Specialist Services which are Benefits must be submitted to PMI within ninety (90) days after completion of treatment. Failure to submit a claim within ninety (90) days will not invalidate nor reduce that claim if it can be shown not to have been reasonably possible to submit the claim within ninety (90) days and that the claim was submitted as soon as reasonably possible, but in no event later than one year from the time otherwise required.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. PMI may also request that an Enrollee obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of benefits.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by PMI. PMI will authorize a second opinion by an out-of-network provider if an appropriately qualified Contract Dentist is not available. PMI will only pay for a second opinion which PMI has approved or authorized. You will be sent a written notification should PMI decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to *Page 7* for information on Enrollee Complaint procedures.

Coordination of Benefits

This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits under this Program are coordinated with any other group insurance policy or any group dental benefits program, and the determination of which policy or program is primary is governed by the rules stated in the group Contract.

When dental services are provided by Specialists or non-Contract Dentists, Benefits under this Program are coordinated with any similar benefits provided by any other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the group Contract.

An Enrollee must provide to PMI and PMI may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. PMI will, in its sole discretion, determine whether any reimbursement to an insurance company or other organizations is warranted under these coordination of benefits provisions, and any such reimbursement will be deemed to be Benefits under this Program. PMI will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as PMI chooses, the amount of any Benefit paid by PMI which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

PMI shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of PMI, or the quality of dental services performed by a Contract Dentist, you may call PMI's Customer Relations department at (800) 422 4234, or the complaint may be addressed in writing to:

PMI Quality Management Department
12898 Towne Center Drive
MS QM600
Cerritos, California 90703-8579

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Applicant and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you should file a request for review (a complaint) with PMI within 180 days after receipt of the adverse determination. PMI's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, PMI will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, PMI shall consult with a dentist who has appropriate training and experience. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within five calendar days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to the complainant an acknowledgment of receipt of the complaint. Certain complaints may require that the complainant be referred to a regional dentist for a clinical evaluation of the dental services provided. PMI will forward to the complainant a determination, in writing, within 30 days of receipt of a complaint. PMI will respond, within 3 days of receipt, to complaints involving severe pain and/or imminent and serious threat to a patient's dental health.

If you have completed PMI's grievance process, or you have been involved in PMI's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 422-4234** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR)*. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

*IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Pension and Welfare Benefits Administration for further review of the claim or if you have questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Any dispute arising out of or relating to this Contract or this dental health care program, including any disagreement with a claim determination made by PMI after exhaustion of the procedures outlined above, or any complaint regarding the quality of dental services performed by a Contract Dentist, Contract Orthodontist or Contract Specialist, which is not resolved within a reasonable period of time by authorized representatives of PMI and California State University, shall be brought to the attention of the Chief Executive Officer (or designated representative) of PMI and the Chief Business Officer (or designee) of California State University for joint resolution. At the request of either party, California State University shall provide a forum for discussion of the disputed item(s), at which time the Executive Vice Chancellor and Chief Financial Officer (or designated representative) of California State University shall be available to assist in the resolution by providing advice to both parties regarding California State University contracting policies and procedures. If resolution of the dispute through these means is pursued without success, either party may seek resolution employing whatever remedies exist in law or equity beyond this Contract.

Prepayment of Premiums

This Program requires premiums to be paid to PMI by CSU. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment.

Standing Committee on Public Policy

A seven member committee, comprised of two providers, one of which is a Dentist, four representatives from the purchaser and subscriber community and one member of the PMI Board of Directors, meets quarterly and participates in establishing policies to assure the comfort, dignity, and convenience of Enrollees and the public. Issues may be presented to this committee by writing to PMI's Public Policy Committee, c/o Professional Relations, at the address on the back of this booklet.

Eligibility for Benefits

New employees who are eligible must enroll themselves and Eligible Dependents within sixty (60) days of employment or during open enrollment. New dependents should be enrolled as soon as they become dependents, and they will then immediately be covered for dental benefits on the first of the month following enrollment or attainment of dependent status if enrollment documents are received in a timely manner.

All eligible active employees who are appointed half-time or more for more than six months and who complete the enrollment process determined by the CSU Trustees are eligible for this Dental Care Program. Employees in certain academic year classifications may also be eligible if appointed for at least (6) weighted teaching units for at least one semester or two or more consecutive quarter terms. All retirees who are eligible to enroll as determined by the CSU Trustees are also eligible for this Dental Care Program.

Enrolled under the Basic Plan

Public Safety (Unit 8)

Retirees (STRS and PERS)

E99s

CMA Operating Engineers (Unit 10)

Enrolled under the Enhanced Plan

Management Personnel Plan (M80)

Executives (M98)

Physicians (Unit 1)

CSEA (Units 2, 5, 7 and 9)

Faculty (Unit 3)

Academic Support (Unit 4)

Retirees (FERP Participants)

Confidential employees (C99)

Skilled Crafts (Unit 6)

If you are on an approved leave of absence, you will continue to be covered if you make applicable payments directly to PMI.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Group.

Dependents become eligible at the same time as the Eligible Employee, immediately upon becoming dependents or at any time subject to a change in legal custody or lawful order to provide Benefits. Eligible Dependents include a lawful husband or wife (unless legally separated or divorced), or a Domestic Partner (until such partnership is terminated by either or both of the parties), and unmarried dependent children from birth until the end of the month in which the child reaches age 23. Children include natural children recognized by the father, step-children, adopted children, children of a Domestic Partner and a child living with the employee in a parent-child relationship who is economically dependent upon the employee. Newborn infants are covered from and after the moment of birth. Notification of birth must be received within sixty (60) days after the date of birth for coverage to continue beyond sixty (60) days. Adopted children are eligible from and after the moment the child is placed in the physical custody of the Eligible Employee for adoption.

An unmarried dependent 23 years or over may continue to be eligible if incapable of self-support because of a physical disability or mental incapacity that began before reaching age 23, and if chiefly dependent on the Eligible Employee for support and maintenance. Proof of these facts must be given to PMI not less than 31 days prior to the dependent's attainment of age 23. Proof will not be required more than once a year after the dependent has reached age 23.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

Employees or retirees may not enroll in more than one state-sponsored plan at the same time. An employee or retiree who is also a family member of an employee or retiree may not be enrolled as both an employee or retiree and a family member.

Dependents in the military service are not eligible. No one may be an Eligible Dependent if eligible as an Eligible Employee, and no one may be an Eligible Dependent of more than one Eligible Employee. Medicare eligibility will not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Renewal and Termination of Benefits

This Program renews on the anniversary of the Contract term unless PMI provides notice of a change in premiums or Benefits and the Group does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. PMI is not obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment

Subject to any continued coverage option, enrollment of an Enrollee under the Program may be cancelled, or renewal of enrollment refused, in the following events:

1. Upon thirty (30) days notice if the Program is terminated or not renewed.
2. Immediately upon loss of eligibility.
3. Upon fifteen (15) days written notice if the premiums are not paid by or on behalf of the Enrollee on the date due, provided, however, that the Enrollee may continue to receive Benefits during the fifteen (15) day period and may be reinstated during the term of this Program upon payment of any unpaid premiums.
4. Upon thirty (30) days written notice if the Enrollee is guilty of misconduct detrimental to the delivery of services while in the facility of a Contract Dentist.
5. Upon thirty (30) days written notice if the Enrollee knowingly perpetrates or permits another person to perpetrate fraud or deception in obtaining Benefits under this Program.
6. Upon thirty (30) days written notice if the Enrollee fails to pay applicable Copayments; provided, however, that the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges.
7. Upon thirty (30) days written notice upon failure of an Enrollee and a Contract Dentist to establish a satisfactory patient-dentist relationship if it is shown that PMI has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist, and the Enrollee has been notified in writing at least thirty (30) days in advance that PMI considers the patient-dentist relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid cancellation, and the Enrollee has failed to make such changes.

If you believe that enrollment has been cancelled or not renewed because of your health status or requirements for health care services, (or that of your dependent[s]) you may request a review by the Director of the Department of Managed Health Care of the State of California, by calling (888) HMO-2219.

Cancellation of enrollment of a Primary Enrollee will automatically cancel the enrollment of a Dependent Enrollee.

Continuation Option

Enrollees who lose coverage under this Program due to certain "Qualifying Events" are entitled to continue coverage at their own expense if the Group is subject to COBRA. Domestic partners and their children are eligible to receive benefits under the Continuation Option.

Primary Enrollees and Dependent Enrollees losing coverage due to either of the following Qualifying Events may elect to continue coverage for 18 months following the month in which the event occurs:

1. The Primary Enrollee's termination of employment, other than for gross misconduct; or
2. The Primary Enrollee's reduction in work hours to less than any minimum required to be eligible under this Program.

Primary Enrollees and their Dependent Enrollees may continue coverage for 29 months if the Primary Enrollee is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time Qualifying Events 1 or 2 above occurred, or to have become so disabled within sixty (60) days after such event occurred, provided notice of such determination is given to your employer during the initial 18 months and within sixty (60) days after the date of determination, and provided further that extended coverage terminates the month that begins more than thirty (30) days after the date of the final determination that the person is no longer disabled.

Dependent Enrollees losing coverage due to any of the following Qualifying Events may elect to continue coverage for 36 months following the month in which the event occurs:

1. A Primary Enrollee's death;
2. A divorce, legal separation or dissolution of a registered domestic partnership from a Primary Enrollee;
3. A dependent child's ceasing to qualify as an Eligible Dependent under this Program;
or
4. A Primary Enrollee's qualification for Medicare Benefits.

Anyone who is entitled to elect continued coverage based on more than one Qualifying Event will be limited to continued coverage for a total of 36 months following the date of the first Qualifying Event.

A proceeding in a case under Title 11, United States Code with respect to the Group, which results in a substantial elimination of coverage under this Program (within one year before or one year after the date of commencement of the proceeding) of a retired employee (who retired on or before the date of substantial elimination of coverage), of the spouse and dependent children of a retired employee, or of the surviving spouse of a retired employee, is a Qualifying Event, and the individuals losing coverage may elect to continue coverage until death (in the case of the retired employee or the surviving spouse of the retired employee) or for 36 months after death of the retired employee (in the case of the spouse and dependent children of the retired employee).

SCHEDULE A

Description of Benefits and Copayments

The benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions and governing administrative policies of the program. Please refer to *Schedules B, C and F* for further clarification of benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Codes and/or text that appear in italics below are specifically intended to clarify the delivery of benefits under the DeltaCare program and are not to be interpreted as CDT-4 procedure codes, descriptors or nomenclature which are under copyright by the American Dental Association.

Code	Description	ENROLLEE PAYS
D0100-D0999 I. Diagnostic		
D0120	Periodic oral evaluation	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings) - limited to 1 series every 24 months	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical, each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing <i>radiograph</i> - single film	No Cost
D0272	Bitewings <i>radiographs</i> - two films	No Cost
D0274	Bitewings <i>radiographs</i> - four films - limited to 1 series every 6 months	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	No Cost
D1000-D1999 II. Preventive		
D1110	Prophylaxis <i>cleaning</i> - adult - 2 per 12 month period	No Cost
D1120	Prophylaxis <i>cleaning</i> - child - 2 per 12 month period	No Cost
D1201	Topical application of fluoride (including prophylaxis) - child - to age 19; 1 per 6 month period	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child - to age 19; 1 per 6 month period	No Cost
D1330	Oral hygiene instructions	No Cost

D1351	Sealant - per tooth - limited to permanent molars up to age 14	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Recementation of space maintainer	No Cost

D2000-D2999 III. Restorative

Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- ¹ Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast posts and cores, inlays and onlays.
- ² Porcelain or other tooth colored material on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$75.00.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2510	Inlay - metallic - one surface ¹	No Cost
D2520	Inlay - metallic - two surfaces ¹	No Cost
D2530	Inlay - metallic - three or more surfaces ¹	No Cost
D2543	Onlay - metallic - three surfaces ¹	No Cost
D2544	Onlay - metallic - four or more surfaces ¹	No Cost
D2710	Crown - resin (indirect)	No Cost
D2720	Crown - resin with high noble metal ^{1,2}	No Cost
D2721	Crown - resin with predominantly base metal ²	No Cost
D2722	Crown - resin with noble metal ²	No Cost
D2740	Crown - porcelain/ceramic substrate ²	No Cost
D2750	Crown - porcelain fused to high noble metal ^{1,2}	No Cost
D2751	Crown - porcelain fused to predominantly base metal ²	No Cost
D2752	Crown - porcelain fused to noble metal ²	No Cost
D2780	Crown - ¾ cast high noble metal ¹	No Cost
D2781	Crown - ¾ cast predominantly base metal	No Cost
D2782	Crown - ¾ cast noble metal	No Cost
D2790	Crown - full cast high noble metal ¹	No Cost
D2791	Crown - full cast predominantly base metal	No Cost
D2792	Crown - full cast noble metal	No Cost
D2910	Recement inlay	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost

Code	Description	ENROLLEE PAYS
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2940	Sedative filling	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Cast post and core in addition to crown - includes canal preparation ¹	No Cost
D2953	Each additional cast post - same tooth - includes canal preparation ¹	No Cost
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	No Cost
D2957	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	No Cost

D3000-D3999 IV. Endodontics

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3310	Root canal - anterior (excluding final restoration)	No Cost
D3320	Root canal - bicuspid (excluding final restoration)	No Cost
D3330	Root canal - molar (excluding final restoration)	No Cost
D3346	Retreatment of previous root canal therapy - anterior	No Cost
D3347	Retreatment of previous root canal therapy - bicuspid	No Cost
D3348	Retreatment of previous root canal therapy - molar	No Cost
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (to age 14)	No Cost
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (to age 14)	No Cost
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) (to age 14)	No Cost
D3410	Apicoectomy/periradicular surgery - anterior	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root)	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation, per root - not covered in conjunction with procedure D3920	No Cost

D4000-D4999 V. Periodontics

Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant ..	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost

D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant.....	No Cost
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant.....	No Cost
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - <i>limited to</i> <i>4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant - <i>limited to 4 quadrants</i> <i>during any 12 consecutive months</i>	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 2 treatments</i> <i>each 12 month period</i>	No Cost

D5000-D5899 VI. Prosthodontics (removable)

D5110	Complete denture - maxillary	No Cost
D5120	Complete denture - mandibular	No Cost
D5130	Immediate denture - maxillary	No Cost
D5140	Immediate denture - mandibular	No Cost
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	No Cost
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	No Cost
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth) ..	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture	No Cost
D5710	Rebase complete maxillary denture	No Cost
D5711	Rebase complete mandibular denture	No Cost
D5720	Rebase maxillary partial denture	No Cost
D5721	Rebase mandibular partial denture	No Cost

D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	No Cost
D5751	Reline complete mandibular denture (laboratory)	No Cost
D5760	Reline maxillary partial denture (laboratory).....	No Cost
D5761	Reline mandibular partial denture (laboratory)	No Cost
D5820	Interim partial denture (maxillary) - <i>limited to initial placement</i> <i>of interim partial denture /stayplate to replace</i> <i>extracted anterior teeth during healing</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to initial placement</i> <i>of interim partial denture /stayplate to replace</i> <i>extracted anterior teeth during healing</i>	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. Maxillofacial Prosthetics - Not Covered

D6000-D6199 VIII. Implant Services - Not Covered

D6200-D6999 IX. Prosthodontics, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]).

¹ Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast and post cores, inlays and onlays.

² Porcelain or other tooth colored material on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$75.00.

D6210	Pontic - cast high noble metal ¹	No Cost
D6211	Pontic - cast predominantly base metal	No Cost
D6212	Pontic - cast noble metal	No Cost
D6240	Pontic - porcelain fused to high noble metal ^{1,2}	No Cost
D6241	Pontic - porcelain fused to predominantly base metal ²	No Cost
D6242	Pontic - porcelain fused to noble metal ²	No Cost
D6250	Pontic - resin with high noble metal ^{1,2}	No Cost
D6251	Pontic - resin with predominantly base metal ²	No Cost
D6252	Pontic - resin with noble metal ²	No Cost
D6602	Inlay - cast high noble metal, two surfaces ¹	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces ¹	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Inlay - cast noble metal, two surfaces	No Cost
D6607	Inlay - cast noble metal, three or more surfaces	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces ¹	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces	No Cost
D6615	Onlay - cast noble metal, three or more surfaces	No Cost
D6720	Crown - resin with high noble metal ^{1,2}	No Cost
D6721	Crown - resin with predominantly base metal ²	No Cost

D6722	Crown - resin with noble metal ²	No Cost
D6750	Crown - porcelain fused to high noble metal ^{1,2}	No Cost
D6751	Crown - porcelain fused to predominantly base metal ²	No Cost
D6752	Crown - porcelain fused to noble metal ²	No Cost
D6780	Crown - ¾ cast high noble metal ¹	No Cost
D6781	Crown - ¾ cast predominantly base metal	No Cost
D6782	Crown - ¾ cast noble metal	No Cost
D6790	Crown - full cast high noble metal ¹	No Cost
D6791	Crown - full cast predominantly base metal	No Cost
D6792	Crown - full cast noble metal	No Cost
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Cast post and core in addition to fixed partial denture retainer - includes canal preparation ¹	No Cost
D6971	Cast post as part of fixed partial denture retainer - includes canal preparation ¹	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer - base metal post; includes canal preparation	No Cost
D6973	Core buildup for retainer, including any pins	No Cost
D6976	Each additional cast post - same tooth - includes canal preparation ¹	No Cost
D6977	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	No Cost

D7000-D7999 X. Oral and Maxillofacial Surgery

Includes preoperative and postoperative evaluations and treatment under local anesthetic.

D7111	Coronal remnants - deciduous teeth (extraction)	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No Cost
D7220	Removal of impacted tooth - soft tissue	No Cost
D7230	Removal of impacted tooth - partially bony	No Cost
D7240	Removal of impacted tooth - completely bony	No Cost
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	No Cost
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7285	Biopsy of oral tissue - hard (bone, tooth) - does not include pathology laboratory procedures	No Cost
D7286	Biopsy of oral tissue - soft (all others) - does not include pathology laboratory procedures	No Cost
D7310	Alveoloplasty in conjunction with extractions - per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7471	Removal of lateral exostosis - (maxilla or mandible)	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost

D8000-D8999 XI. Orthodontics

³ Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee". Beyond 24 months of active treatment, an additional monthly fee of \$25.00 applies.

⁴ In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.

⁵ Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$25.00 applies.

D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent ³	\$1400.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - dependent children to age 23 ³	\$1400.00
D8090	Comprehensive orthodontic treatment of the adult dentition - adults ³	\$1600.00
D8660	Pre-orthodontic treatment visit - not to be charged with any other consultation procedure(s) ⁴	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) ⁵	No Cost
D8999	Unspecified orthodontic procedure, by report -includes START UP FEES (including initial examination, diagnosis, consultation and initial banding)	\$350.00

D9000-D9999 XII. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes - for extractions only and only when medically necessary	No Cost
D9310	Consultation (diagnostic services provided by a dentist or physician other than practitioner providing treatment)	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	No Cost
D9951	Occlusal adjustment - limited	No Cost
D9952	Occlusal adjustment - complete	No Cost
D9999	Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice	\$ 5.00

Procedures not listed above are not covered however may be available at the Contract Dentist's "filed fees".

"Filed fees" mean the Contract Dentist's fees on file with PMI. Questions regarding these fees should be directed to PMI's Customer Relations department at (800) 422-4234.

SCHEDULE B LIMITATIONS OF BENEFITS

1. Prophylaxis is limited to two treatments in a 12 month period (includes periodontal maintenance);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any three year period from initial placement;
3. Partial dentures are not to be replaced within any three year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and bridges are not to be replaced within any three year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal scaling and root planing are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. Full mouth x-rays are limited to one set every 24 consecutive months;
10. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application;
11. General anesthesia and the services of a special anesthesiologist for extractions only and only when medically necessary;
12. Accidental injury except as noted in Accident Injury Rider. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

EXCLUSIONS OF BENEFITS

1. Cosmetic dental care;
2. Dental conditions arising out of and due to Enrollee's employment or for which Worker's Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code;
3. Dental services performed in a hospital and related hospital fees;
4. Treatment of fractures and dislocations;
5. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage;
7. Any service that is not specifically listed as a covered expense;
8. Dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare program. Example: teeth prepared for crowns, root canals in progress;
9. Congenital malformations (e.g. congenitally missing teeth, supernumerary);
10. Treatment of malignancies, cysts and neoplasms except as noted in the Description of Benefits and Copayments;
11. Dispensing of drugs not normally supplied in a dental facility;
12. Cases which in the professional judgment of the attending Contract Dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
13. Dental services received from any dental facility other than the assigned Contract facility, unless expressly authorized in writing by PMI or as cited under "Out of Area Emergency Treatment";
14. Prophylactic removal of impactions (asymptomatic nonpathological);
15. "Specialist consultations" for noncovered benefits;
16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
17. Crown lengthening procedures.

ORTHODONTIC LIMITATIONS

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in the Description of Benefits and Copayments subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist;
2. Plan benefits cover 24 months of usual and customary orthodontic treatment;
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not PMI will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300 for dependent children to age 23 and \$2,500 for adults. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. **Start-up fees are included in these amounts;**
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years;
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost;
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same copayment amount as for fixed appliances.
8. Orthodontic Treatment in Progress is limited to new DeltaCare Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan as long as they continue to be eligible under the DeltaCare program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. PMI is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

ORTHODONTIC EXCLUSIONS

1. Pre, mid and post treatment records which include cephalometric x-rays, tracings, photographs and study models;
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
3. Retreatment of orthodontic cases;
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
5. Surgical procedures incidental to orthodontic treatment;
6. Myofunctional therapy;
7. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance;
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics;
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to a per office visit charge of \$25.00;
11. Restorative work caused by orthodontic treatment;
12. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
13. Extractions solely for the purpose of orthodontics;
14. Transfer after banding has been initiated;
15. Lingually placed direct banded appliances, brackets and arch wires (invisible braces).

* *Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.*

SCHEDULE C GOVERNING ADMINISTRATIVE POLICIES

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment plans.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the Enrollee selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment plus any copayment for covered benefits.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the three year limitation for replacement.

A. PARTIAL DENTURES

A removable cast metal partial denture is considered an adequate restoration. If the Enrollee selects another course of treatment, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment, plus any copayment for the covered benefit.

If a cast metal partial denture will restore the case, the Contract Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the Enrollee and dentist may choose to use. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and the optional treatment plus any copayment for the covered benefit.

An acrylic partial denture is the covered benefit in cases involving extensive periodontal disease.

B. COMPLETE DENTURES

If, in the construction of a denture, the Enrollee and the Contract Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Full upper and/or lower dentures are not to exceed one each in any three year period from initial placement. The Enrollee is entitled to a new upper or lower denture only if the existing denture is more than three years old and cannot be made satisfactory by either relining or repair.

C. FILLINGS AND CROWNS

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

The DeltaCare program provides amalgam and resin restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Composite resin restorations in posterior teeth are considered optional treatment. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a three year period from initial placement.

A pulp cap is a benefit only on a permanent tooth with an open apex.

D. FIXED BRIDGES

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the Enrollee's oral health and general dental condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a three year period from initial placement and shall be covered only when the replacement duplicates the original bridge.

Fixed bridges are not a benefit for patients under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

E. RECONSTRUCTION

The DeltaCare program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare program. The program will allow for complete or partial denture(s).

F. SPECIALIZED TECHNIQUES

Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

G. PREVENTIVE CONTROL PROGRAMS

Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special tooth brush, etc., is considered as optional treatment. If performed, the Enrollee is responsible for the cost.

H. INTERIM PARTIAL DENTURES (STAYPLATES)

Stayplates are a covered benefit only to replace extracted anterior teeth in adults during the healing period and as an anterior space maintainer for children.

I. FRENECTOMY

The frenum can be excised when the tongue has limited mobility; or has a large diastema between teeth; or when the frenum interferes with a prosthetic appliance.

J. PEDODONTIA

Pedodontic referrals must be preauthorized by PMI. Benefits for dependent children to age 19 are covered at 100% of the Specialist's fee less any applicable copayments for covered benefits to a maximum of \$500 per child in a calendar year.

K. CORRECTION OF OCCLUSION

Selective equilibration of the dentition or restorations, not to include treatment of full mouth occlusal dysfunction.

L. TREATMENT PLANNING

The objective of this Program is to see that all Enrollees are brought to a good level of oral health and that this level of oral health is maintained. To achieve this objective takes careful treatment planning. Priorities have been established on the following basis:

1. Priority attention is given to those procedures that, if not done first, could have an immediate effect on the Enrollee's overall oral health.
2. Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the Enrollee's oral health.
3. Priority is then given to replacement of missing teeth not causing a gross lack of function.

Exceptions are made to this treatment planning concept based on individual circumstances.

"Filed fees" mean the Contract Dentist's fees on file with PMI. Questions regarding these fees should be directed to PMI's Customer Relations department at (800) 422-4234.

SCHEDULE F ACCIDENT INJURY RIDER

PMI shall pay or otherwise discharge 100% of the Dentist's "Usual Fee" not to exceed the "Prevailing Fee" as determined by PMI or of Fees Actually Charged, whichever is less, less any applicable Enrollee copayment(s), for the following Dental Accident Benefits:

Services described in the Schedule of Benefits and Copayments, Schedule A, and in paragraph II of this Rider, Schedule F are subject to the following maximum, limitation and exclusions when provided for conditions caused directly and independently of all other causes, by external, violent and accidental means.

I. DEFINITIONS

For the purpose of this Rider, the following additional definitions shall apply:

- A. "Attending Dentist's Statement" means the standard form used to file a claim.
- B. "Dental Accident Benefits" means those dental services which are provided under the terms of this Rider for conditions caused directly and independently of all other causes, by external, violent and accidental means.
- C. "Fee Actually Charged" means the fee for a particular dental service or procedure which a Dentist reports to PMI on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, rebated or which the Dentist does not in good faith attempt to collect.
- D. "Prevailing Fee" means the fee for a Single Procedure which satisfies the majority of Dentists in California, as determined by PMI.
- E. "Single Procedure" means a dental procedure listed on a separate line in Schedule A and in paragraph II of this Rider, Schedule F.
- F. "Usual Fee" - A usual fee is the fee regularly charged and received by an individual Dentist, (i.e., his own usual fee). If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to Enrollee.

II. DENTAL ACCIDENT BENEFITS

For the purpose of this Rider, the following additional benefits shall apply:

- A. Intra-oral grafting
- B. Reimplantation
- C. Splinting
- D. Stayplate

III. MAXIMUM

The program shall provide Dental Accident Benefits for an Eligible Person up to a maximum of \$1,600 per Enrollee per any 12 month period.

IV. LIMITATION

Dental Accident Benefits shall be limited to services provided to an Eligible Person within 180 days following the date of accident, and shall not include any services for conditions caused by an accident occurring prior to the Enrollee's eligibility date.

V. EXCLUSIONS

The following services are not Dental Accident Benefits:

- A. Services for injuries or conditions which are benefits provided to the Enrollee through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
- B. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- C. Services for restoring or stabilizing tooth structure lost from wear, or for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion. Such services include but are not limited to: equilibration and periodontal splinting.
- D. Prosthodontic services or any single procedure started prior to the date the Enrollee became eligible for such services under this Contract.
- E. Prescribed drugs, pre-medication or analgesia.
- F. Experimental procedures.
- G. Prophylaxis.
- H. All hospital costs and any additional fees charged by the Dentist for hospital treatment.
- I. Charges for general anesthesia.
- J. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- K. Implants (materials implanted into or on bone or soft tissue), the removal of implants or procedures related to the placement or removal of implants.
- L. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- M. Replacement of existing restorations due to carious lesions.
- N. Orthodontic services (treatment of malalignment of teeth and/or jaws).

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

If you have any questions or need additional information, call or write:

Toll Free
(800) 422-4234

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579
(562) 924-8311

Did you know you could refer to our web site for a listing of DeltaCare Dentists?

Visit www.deltadentalca.org/pmi and click on the Dentist Directory, DeltaCare Dentists and All States. You can also change your facility assignment, change your mailing address, request ID cards or an Evidence of Coverage booklet online. From the home page, simply click on Contact Us, Customer Relations and the Online Customer Service Request for DeltaCare (administered by PMI).