

Dental Health Care Program  
for Eligible Employees  
and Dependents

**California State University  
Basic Benefit**

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

*Provided by:*



DENTAL HEALTH PLAN  
An Affiliate of Delta Dental Plan  
of California

12898 Towne Center Drive  
Cerritos, CA 90703-8579  
(800) 422-4234

CAEOC

## **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 office of the assigned Network 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.

**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.

**NETWORK DENTIST** means a Dentist who has contracted with PMI to provide Benefits to Enrollees.

**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.

**SPECIALIST SERVICES** means services performed by a Dentist who specializes in a particular type of dental care (i.e., oral surgery, endodontics, periodontics) and which must be preauthorized in writing by PMI.

## **How to use the DeltaCare Program - Choice of Network Dentist**

When you enroll in this Program, you must select one Network Dentist for both yourself and any Dependent Enrollee from the list of Network Dentists furnished with the enrollment forms. If you fail to select a Network Dentist or the Network Dentist selected becomes unavailable, PMI will request the selection of another Network Dentist or assign you to a Network Dentist. While it is PMI's preference that changes in Network 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 office selected or have a change in family status or residence. In order to ensure that your Network Dentist is notified and PMI eligibility lists are correct, changes in Network 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 Network Dentist. After the effective date in your membership packet, you may obtain dental services. Simply call your Network Dentist office 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 NETWORK 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 NETWORK DENTIST'S OFFICE. ANY OTHER TREATMENT PROVIDED BY A NON-NETWORK DENTIST IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Network Dentist's contract with PMI terminates, that Network 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 Network 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 Network 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-Network Dentist, you may be liable to that Dentist for the cost of services.

## **Provider Compensation**

A Network 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 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 office of the Network Dentist, then PMI shall reimburse the Enrollee for the cost of such Emergency Services less any applicable Copayment, up to a maximum of \$50.00, 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 Network 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 \$50.00, per occurrence; and

- that you must submit a claim within ninety (90) days after receiving the treatment; and
- that you must visit your Network 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 Network Dentist's office because of a physical handicap, and (b) the Enrollee's inability to comply with the Network Dentist's instructions during examination or treatment because of physical handicap 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 Network Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

### **Dental Office Accessibility**

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

### **Relationship With non-Network Dentists**

PMI may require a non-Network 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-Network Dentist.

### **Specialist Services**

Specialist Services must be referred by a Network 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 Network Dentist. All Benefits provided by your Network Dentist are in accordance with Dental Care Guidelines which establish the standard of care to be followed by Network 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 Network 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 rendered in a timely manner, appropriate to the nature of the Enrollee's condition by a licensed Dentist. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, you should contact PMI's Customer Relations department at (800) 422-4234 or write to the address on the back of this booklet. Second opinions will be provided at another Network Dentist office, unless otherwise authorized by PMI's dental consultant. PMI will pay only for a second opinion which PMI has approved or authorized.

## **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-Network 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 Network Dentist, Network Orthodontist or Network 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  
Skilled Crafts (Unit 6) - through July 31, 2003  
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) - effective August 1, 2003

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, as defined by the Internal Revenue Service. 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 covered as an Eligible Employee, and no one may be a covered 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 office of a Network 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 Network 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 Network 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

These procedures are performed as needed and deemed necessary by your attending Network Dentist subject to the Limitations, Exclusions and Governing Administrative Policies of the program.

PROCEDURE CODES		ENROLLEE PAYS
<b>I. DIAGNOSTIC</b>		
	Office visit, per visit (in addition to other services) .....	No Cost
0120	Periodic oral evaluation .....	No Cost
0140	Limited oral evaluation—problem focused .....	No Cost
0150	Comprehensive oral evaluation .....	No Cost
0160	Detailed and extensive oral evaluation—problem focused .....	No Cost
0210	Intraoral radiographs—complete series (including bitewings) .....	No Cost
0220,0230	Intraoral periapical film .....	No Cost
0240	Intraoral occlusal film .....	No Cost
0250,0260	Extraoral - 1st film; each additional film .....	No Cost
0270,0272,		
0273,0274	Bitewing radiograph(s) .....	No Cost
0330	Panoramic film .....	No Cost
0460	Pulp vitality tests .....	No Cost
<b>II. PREVENTIVE</b>		
1110,1120	Prophylaxis (cleaning)—adult/child - 2 per 12 months .....	No Cost
1201	Topical application of fluoride, including prophylaxis (to age 19) - 1 per 6 month period .....	No Cost
1203	Topical application of fluoride, excluding prophylaxis (to age 19) - 1 per 6 month period .....	No Cost
1330	Oral hygiene instructions .....	No Cost
1351	Sealant, per tooth .....	\$ 5.00
1510	Space maintainer—fixed—unilateral .....	\$ 10.00
1515	Space maintainer—fixed—bilateral .....	\$ 10.00
1520	Space maintainer—removable—unilateral .....	\$ 10.00
1525	Space maintainer—removable—bilateral .....	\$ 10.00
1550	Recementation of space maintainers .....	No Cost
<b>III. RESTORATIVE (Fillings)</b>		
(Includes indirect pulp capping, bases, liners and acid etch procedures)		
2110	Amalgam—one surface, primary .....	No Cost
2120	Amalgam—two surfaces, primary .....	No Cost
2130	Amalgam—three surfaces, primary .....	No Cost
2131	Amalgam—four or more surfaces, primary .....	No Cost
2140	Amalgam—one surface, permanent .....	No Cost
2150	Amalgam—two surfaces, permanent .....	No Cost
2160	Amalgam—three surfaces, permanent .....	No Cost
2161	Amalgam—four or more surfaces, permanent .....	No Cost
2210	Silicate cement - per restoration .....	No Cost
2330	Resin—one surface anterior .....	No Cost
2331	Resin—two surface anterior .....	No Cost
2332	Resin—three surface anterior .....	No Cost

PROCEDURE CODES		ENROLLEE PAYS
2335	Resin—four or more surfaces or involving incisal angle (anterior) .....	No Cost
2336	Composite resin crown, anterior—primary .....	No Cost
2940	Sedative filling .....	No Cost
2951	Pin retention—per tooth, in addition to restoration .....	No Cost

#### IV. ORAL SURGERY

(Includes preoperative and postoperative evaluations and treatment under local anesthetic)

7110,7120	Single tooth extraction/each additional .....	No Cost
7130	Root removal—exposed roots .....	No Cost
7210	Surgical removal of erupted tooth .....	No Cost
7220	Removal of impacted tooth—soft tissue .....	No Cost
7230	Removal of impacted tooth—partially bony .....	\$ 15.00
7240,7241	Removal of impacted tooth—completely bony .....	\$ 25.00
7250	Surgical removal of residual tooth roots (cutting procedure) ....	No Cost
7285,7286	Biopsy of oral tissue—hard/soft .....	No Cost
7310	Alveoloplasty in conjunction with extractions, per quadrant .....	No Cost
7320	Alveoloplasty not in conjunction with extractions, per quadrant	No Cost
7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm .....	No Cost
7470	Removal of exostosis—maxilla or mandible .....	No Cost
7510	Incision and drainage of abscess—intraoral soft tissue .....	No Cost
7960	Frenulectomy—(frenectomy or frenotomy) separate procedure	No Cost

#### V. PERIODONTICS

(Includes preoperative and postoperative evaluations and treatment under a local anesthetic)

4210	Gingivectomy or gingivoplasty, per quadrant .....	\$ 20.00
4211	Gingivectomy or gingivoplasty, per tooth (fewer than six teeth)	No Cost
4220	Gingival curettage surgical, per quadrant .....	\$ 10.00
4240	Gingival flap procedures including root planing (per quadrant) .	\$ 80.00
4250	Mucogingival surgery, per quadrant .....	\$ 80.00
4260	Osseous surgery, flap entry and closure, per quadrant .....	\$ 80.00
4341	Periodontal scaling and root planing, per quadrant .....	\$ 10.00
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis .....	\$ 10.00
4910	Periodontal maintenance (following active therapy) .....	\$ 8.00

#### VI. PROSTHETICS

(Crowns, bridges and dentures)

2510	Inlay—one surface—base metal noble .....	\$ 50.00
2520,6520	Inlay—two surfaces—base metal noble .....	\$ 50.00
2530,6530	Inlay—three or more surfaces—base metal noble .....	\$ 50.00
2543,6543	Onlay—three surfaces—base metal noble .....	\$ 50.00
2544,6544	Onlay—four or more surfaces—base metal noble .....	\$ 50.00
2710	Crown—resin (laboratory) .....	\$ 35.00
2720	Crown—resin with high noble metal*† .....	\$ 50.00
2740	Crown—porcelain/ceramic† .....	\$ 50.00
2750	Crown—porcelain fused to high noble metal*† .....	\$ 50.00

PROCEDURE CODES		ENROLLEE PAYS
2751	Crown—porcelain fused to predominantly base metal† .....	\$ 50.00
2752	Crown—porcelain fused to noble metal† .....	\$ 50.00
2790	Crown—full cast high noble metal* .....	\$ 50.00
2791	Crown—full cast predominantly base metal .....	\$ 50.00
2792	Crown—full cast noble metal .....	\$ 50.00
2810	Crown—3/4 cast metal noble .....	\$ 50.00
2910	Recement inlay .....	No Cost
2920	Recement crown .....	No Cost
2930,2931	Crown—prefabricated stainless steel—primary/permanent .....	No Cost
2950	Crown buildup (restorative material and pins) .....	No Cost
2952	Cast post and core* (in addition to crown) .....	No Cost
2954	Prefabricated post and core (in addition to crown) .....	No Cost
5110,5120	Denture—complete maxillary or mandibular (upper or lower) ..	\$ 60.00
5130,5140	Immediate denture—maxillary or mandibular (upper or lower) .	\$ 60.00
5211,5212	Denture—maxillary or mandibular partial—resin base (including any conventional clasps, rests and teeth) .....	\$ 70.00
5213,5214	Denture—maxillary or mandibular (upper or lower) partial with metal lingual or palatal bar, clasps and acrylic saddles, and acrylic base or cast metal framework and teeth .....	\$ 70.00
5410	Adjust complete denture—maxillary .....	No Cost
5411	Adjust complete denture—mandibular .....	No Cost
5421	Adjust partial denture—maxillary .....	No Cost
5422	Adjust partial denture—mandibular .....	No Cost
5510	Repair broken complete denture base .....	\$ 15.00
5520	Replace missing or broken teeth—complete denture (per tooth)	\$ 15.00
5610	Repair resin denture base .....	\$ 15.00
5620	Repair cast framework .....	\$ 15.00
5630	Repair or replace broken clasp .....	\$ 15.00
5640	Replace broken teeth (per tooth) .....	\$ 15.00
5650	Add tooth to existing partial denture .....	\$ 5.00
5660	Add clasp to existing partial denture .....	\$ 5.00
5730	Reline complete maxillary denture (chairside) .....	No Cost
5731	Reline complete mandibular denture (chairside) .....	No Cost
5740	Reline maxillary partial denture (chairside) .....	No Cost
5741	Reline mandibular partial denture (chairside) .....	No Cost
5710	Rebase complete maxillary denture .....	\$ 15.00
5711	Rebase complete mandibular denture .....	\$ 15.00
5720	Rebase maxillary partial denture .....	\$ 15.00
5721	Rebase mandibular partial denture .....	\$ 15.00
5750	Reline complete maxillary denture (lab) .....	\$ 15.00
5751	Reline complete mandibular denture (lab) .....	\$ 15.00
5760	Reline maxillary partial denture (lab) .....	\$ 15.00
5761	Reline mandibular partial denture (lab) .....	\$ 15.00
5820	Interim partial denture (maxillary) .....	No Cost
5821	Interim partial denture (mandibular) .....	No Cost
5850,5851	Tissue conditioning—per denture .....	No Cost
6210	Pontic—cast high noble metal* .....	\$ 50.00
6211	Pontic—cast predominantly base metal .....	\$ 50.00
6212	Pontic—cast noble metal .....	\$ 50.00

PROCEDURE CODES		ENROLLEE PAYS
6240	Pontic—porcelain fused to high noble metal*†	\$ 50.00
6241	Pontic—porcelain fused to predominantly base metal†	\$ 50.00
6242	Pontic—porcelain fused to noble metal†	\$ 50.00
6720	Crown—resin with high noble metal*†	\$ 50.00
6721	Crown—resin with predominantly base metal†	\$ 50.00
6722	Crown—resin with noble metal†	\$ 50.00
6750	Crown—porcelain fused to high noble metal*†	\$ 50.00
6751	Crown—porcelain fused to predominantly base metal†	\$ 50.00
6752	Crown—porcelain fused to noble metal†	\$ 50.00
6780	Crown—3/4 cast high noble metal*	\$ 50.00
6790	Crown—full cast high noble metal*	\$ 50.00
6791	Crown—full cast predominantly base metal	\$ 50.00
6792	Crown—full cast noble metal	\$ 50.00
6930	Recement bridge (fixed partial denture)	No Cost
6940	Stress breaker, per unit (in addition to mixed partial denture, retainer)	No Cost
6970	Cast post and core* (includes canal preparation)	No Cost
6971	Cast post as part of fixed partial denture retainer*	No Cost
6972	Prefabricated post and core buildup (including canal preparation, restorative material and any pins)	No Cost
6973	Core buildup for retainer - including any pins	No Cost

\* 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.

† There is an additional \$75.00 Copayment for porcelain on a molar.

## VII. ENDODONTICS

3110,3120	Pulp capping (direct/indirect)	No Cost
3220	Therapeutic pulpotomy (excluding final restoration)	No Cost
3310	Root canal therapy—anterior (excluding final restoration)	\$ 20.00
3320	Root canal therapy—bicuspid (excluding final restoration)	\$ 40.00
3330	Root canal therapy—molar (excluding final restoration)	\$ 60.00
3346	Retreatment of previous root canal therapy - anterior	\$ 20.00
3347	Retreatment of previous root canal therapy - bicuspid	\$ 40.00
3348	Retreatment of previous root canal therapy - molar	\$ 60.00
3351	Apexification/recalcification - initial visit (to age 14)	No Cost
3352	Apexification/recalcification - interim medication replacement (to age 14)	No Cost
3353	Apexification/recalcification - final visit (to age 14)	No Cost
3410	Apicoectomy/periradicular surgery—anterior	No Cost
3421	Apicoectomy/periradicular surgery—bicuspid (first root)	No Cost
3425	Apicoectomy/periradicular surgery—molar (first root)	No Cost
3426	Apicoectomy/periradicular surgery (each additional root)	No Cost
3430	Retrograde filling, per root	No Cost
3450	Root amputation, per root	No Cost

## VIII. ADJUNCTIVE GENERAL SERVICES

9110	Palliative (emergency) treatment of dental pain	No Cost
9211	Regional block anesthesia	No Cost

PROCEDURE CODES		ENROLLEE PAYS
9212	Trigeminal division block anesthesia .....	No Cost
9215	Local anesthesia .....	No Cost
9310	Consultation (diagnostic services provided by a dentist or physician other than practitioner providing treatment) .....	No Cost
9430	Office visit for observation (during regularly scheduled hours) - no other services performed .....	No Cost
9440	Office visit after regularly scheduled hours .....	No Cost
0125	Failed appointment without 24 hour notification .....	\$ 5.00
9951	Occlusal adjustment - limited .....	No Cost
9952	Occlusal adjustment - complete .....	No Cost

#### **IX. ORTHODONTICS**

Start-up fees (excluding records) .....	\$ 350.00
Dependent children to age 23 .....	\$1400.00

Any procedure not listed is available on a UCR basis.

### **Schedule B**

#### **Limitations of Benefits**

1. Prophylaxis is limited to two treatments in a twelve month period (includes periodontal maintenance following active therapy);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five 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 five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (root planing/subgingival curettage) 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. 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. General anesthesia and the services of a special anesthesiologist;
2. Cosmetic dental care;
3. 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;
4. Treatment required by reason of war;
5. Dental services performed in a hospital and related hospital fees;
6. Treatment of fractures and dislocations;
7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage;
9. Any service that is not specifically listed as a covered expense;
10. 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, orthodontic treatment;
11. Congenital malformations (e.g., congenitally missing teeth, supernumerary);
12. Treatment of malignancies, cysts and neoplasms except as noted in the Description of Benefits and Copayments;
13. Dispensing of drugs not normally supplied in a dental office;
14. Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;

15. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by PMI or as cited under “Emergency Services/Acute Condition”;
16. Prophylactic removal of impactions (asymptomatic nonpathological);
17. “Specialist consultations” for noncovered benefits;
18. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
19. Crown lengthening procedures.

### **Orthodontic Limitations**

The Program provides coverage for orthodontic treatment plans provided through DeltaCare 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 DeltaCare 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. 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 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 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 patient 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 patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amount as for fixed appliances.

### **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. Treatment in progress at inception of eligibility;
15. Transfer after banding has been initiated;
16. 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 patient selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's usual 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 five year limitation for replacement.

#### **A. PARTIAL DENTURES**

A removable cast metal partial denture is considered an adequate restoration. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentist's usual 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 Network Dentist will apply the difference of the cost of such procedure toward a more complicated precision appliance which the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's usual 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 patient and the Network Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's usual 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 five year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five 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 patient must pay the difference in cost between the dentist's usual 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 patient must pay the difference in cost between the dentist's usual 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 sixteen years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's usual 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 five 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 sixteen years old or older. Such treatment will be covered if the patient'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 patient must pay the difference in cost between the dentist's usual 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 patient must pay the difference in cost between the dentist's usual 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 five 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 sixteen. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the patient must pay the difference in cost between the dentist's usual 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 patient must pay the difference in cost between the dentist's usual 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 patient 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 DeltaCare. 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 patients 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 patient'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 patient'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.

**Schedule F  
Accident Injury Rider**

PMI shall pay or otherwise discharge 100% of the Dentist's Usual, Customary and Reasonable fees not to exceed the "Prevailing Fee" as determined by PMI or of Fees Actually Charged, whichever is less, less any applicable patient 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. Each of the words in the term "Usual, Customary and Reasonable" as used in this Rider shall have the following meanings:

USUAL - 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 patients.

CUSTOMARY - A fee is customary when it is within the accepted range of usual fees charged and received by dentists of similar training for the same service within the geographic area determined by PMI to be statistically relevant.

REASONABLE - A fee is reasonable if it is "usual" and "customary," or if it falls above "customary" and is justifiable due to a level of treatment superior to that customarily provided. Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulties of the case in question.

## 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 patient per any twelve (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 patient'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 eligible person through a medical carrier or are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the Eligible Person by any federal or state government agency or are provided without cost to the Eligible Person 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 person 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