

A Prepaid Dental Plan for

UNIVERSITY OF CALIFORNIA
Employees, Annuitants, and Their Dependents

***EVIDENCE OF COVERAGE AND
DISCLOSURE STATEMENT
January 1, 2004***

Provided by:



DENTAL HEALTH PLAN
An Affiliate of Delta Dental
of California

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

**EVIDENCE OF COVERAGE
DISCLOSURE FORM
OF THE PMI GROUP DENTAL PLAN FOR
ELIGIBLE EMPLOYEES AND ANNUITANTS OF
THE UNIVERSITY OF CALIFORNIA**

DeltaCare Dental Health Care Program

This Evidence of Coverage of the PMI Group Dental Plan has been prepared for participants who are Employees and Annuitants of the University of California.

This booklet describes the plan benefits in everyday terms whenever possible. Not all details are included in every case.

This Plan has been established and is maintained and administered in accordance with the provisions of Group Dental Contract Number AG109.UC issued by:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579
(800) 422-4234
(562) 924-8311

IMPORTANT

This booklet is subject to the provisions of the Group Dental Service Contract and The University of California Group Insurance Regulations and cannot modify or affect the provisions of these documents in any way, nor shall you accrue any rights because of any statement in or omission from this booklet. Some provisions of this Plan may not apply to Employees in certain exclusively represented bargaining units.

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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University of California Eligibility, Enrollment and Plan Administration Provisions January 1, 2004

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own health and welfare plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations (“Regulations”). Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. They are only eligible to enroll in the plan if they meet the Plan's geographic service criteria as residents of California.

Subscriber Employee:

You are eligible if you have an appointment type which is eligible for benefits, and are a member of a UC-sponsored retirement plan. Generally, there are two ways to qualify for UCRP membership: 1) you are appointed to work at least 50% time for a year or more or 2) you worked 1,000* hours in a rolling twelve-month period in a position eligible for UCRP membership. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment.

* Lecturers - see your Benefits Office for eligibility.

** For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

- (a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.
- (b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

Annuitant (including Survivor Annuitant): **Annuitant** - A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor Annuitant - A deceased Employee's or Annuitant's Eligible Dependent receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University dental plan coverage as an Annuitant when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor Annuitant when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

- (a) you meet the University's service credit requirements for Annuitant dental eligibility;
- (b) the effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death for a Survivor Annuitant); and
- (c) you elect to continue dental coverage at the time of retirement.

Eligible Dependents

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
- (c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
- (d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- (a) the incapacity began before age 23, the child was enrolled in a group dental plan before age 23 and coverage is continuous;
- (b) the child is dependent on you for at least 50% of his or her support; and is your dependent for income tax purposes, and
- (c) the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored health plan are eligible for continued coverage under any other University-sponsored dental plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group dental coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents: You may enroll an adult dependent relative or same sex domestic partner (and the same sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations. An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an Eligible Dependent as of December 31, 2003 may continue coverage in UC-sponsored plans. For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, an Annuitant, a Survivor Annuitant or an Eligible Dependent, but not under any combination of these. If an Enrollee and the Enrollee's spouse or same-sex Domestic Partner are both eligible Subscribers, each may enroll separately or one may cover the other as an Eligible Dependent. If they enroll separately, neither may enroll the other as an Eligible Dependent. Eligible children may be enrolled under either parent's or same-sex Domestic Partner's coverage but not under both.

Additionally, a child who is also eligible as a Primary Enrollee may not have dual coverage through two University-sponsored dental plans.

ENROLLMENT

For information about enrolling yourself or an Eligible Dependent, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any Eligible Dependents during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly Eligible Dependent during his or her PIE. The Eligible Dependent's PIE starts the day your Eligible Dependent becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other Eligible Dependent if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any Eligible Dependent. Eligible Dependents are only eligible for the same plan you are enrolled in.

- (a) For a spouse, on the date of marriage. Survivor Annuitants may not add Spouses to their coverage.
- (b) For a natural child, on the child's date of birth.
- (c) For an adopted child, the earlier of: (i) the date you or your Spouse has the legal right to control the child's health care, or (ii) the date the child is placed in your physical custody.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

- (d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your Eligible Dependents because of other group dental plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those Eligible Dependents during a PIE that starts on the day the other coverage is no longer in effect.

If you are in PMI and you move or are transferred out of the PMI service area (California), or will be away from the PMI service area for more than two months, you will have a PIE to enroll yourself and your Eligible Dependents in another University dental plan. Your PIE starts with the effective date of the move or the date you leave the PMI service area.

At Other Times

You and your Eligible Dependents may also enroll during a group open enrollment period established by the University.

If you have two or more Eligible Dependents enrolled in the Plan, you may add a newly Eligible Dependent at any time. See "Effective Date".

If you are an Annuitant, you may continue coverage for yourself and your enrolled Eligible Dependents in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Eligible Dependents before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor Annuitant, you may not enroll your legal spouse or same-sex Domestic Partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Eligible Dependents is effective the date the PIE starts.

If you are an Annuitant continuing enrollment in conjunction with retirement, coverage for you and your Eligible Dependents is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

An Employee or Annuitant already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

- (a) the date the child becomes eligible, or
- (b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Eligible Dependent to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Eligible Dependent stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are an Annuitant or Survivor Annuitant and your annuity terminates, your coverage and that of any enrolled Eligible Dependent stops at the end of the last month in which you are eligible for an annuity.

If your Eligible Dependent loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Eligible Dependent is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Deenrollment Due to Fraud

Coverage for you or your Eligible Dependents may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). An Eligible Dependent who commits fraud or deception will be permanently deenrolled while any other Eligible Dependent and the Subscriber will be deenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Eligible Dependents will be deenrolled for 18 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of an Eligible Dependent ends, you and/or your Eligible Dependent may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UC At Your Service website (<http://atyourservice.ucop.edu>). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the insurance contract. What is written in this document does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
(800) 888-8267

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by PMI at the following address and phone number:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, California 90703-8579
(800) 422-4234
(562) 924-8311

Group Contract Number

The Group Contract Number for this Plan is:
AG109.UC

Type of Plan

This Plan is a health and welfare plan that provides group dental care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, and what portion of the premiums you and the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements

The benefits under the Plan are provided by PMI under a Group Dental Service Contract. The cost of the premiums is currently paid entirely by the University of California.

Agent for Serving of Legal Process

Legal process may be served on PMI, at the address listed above.

Your Rights under the Plan

As a participant in a University of California dental plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the insurance contract, at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Definitions

ACUTE CONDITION - shall mean a condition requiring Emergency Services while a New Member is within twenty-five (25) miles from the facility of the assigned Contract Dentist.

ADDITIONAL FEE(S) - shall mean the difference in cost of the covered benefit and the Usual Fee for Optional treatment.

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

CONTRACT DENTIST means a dentist who provides services in general dentistry and who has contracted with PMI to provide benefits to Members under this Plan.

CONTRACT ORTHODONTIST means a dentist who specializes in orthodontics and who has contracted with PMI to provide benefits to Members under this Plan.

CONTRACT SPECIALIST means a dentist who provides Specialist Services and has contracted with PMI to provide Benefits to Members under this Plan.

COPAYMENT - shall mean the amount listed under "Your Copayment" for services covered in the Description of Benefits and Copayments.

COVERED SERVICES - shall mean the dental health care services described under the terms of the Group Dental Contract.

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.

ELIGIBLE ANNUITANT means any annuitant who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this brochure.

ELIGIBLE DEPENDENT means any dependent of an Eligible Employee or Eligible Annuitant who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

ELIGIBLE EMPLOYEE means any employee who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

EMERGENCY SERVICES - shall mean 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, an Eligible Annuitant or Eligible Dependent enrolled to receive Benefits.

GROUP means the University of California contracting to obtain Benefits.

GROUP DENTAL CONTRACT - shall mean the legal document between the Regents of the University of California and PMI which defines all benefits and terms of dental coverage.

MEDICALLY NECESSARY GENERAL ANESTHESIA - shall mean physical limitations or health conditions that prohibit treatment being rendered under local anesthesia. Such limitations or conditions must be verified in writing by a physician.

MEMBER - shall mean a person who is actually enrolled in the "PMI" plan. The term "Member" or "Members" used herein shall also include all Eligible Employees, Annuitants/Survivor Annuitants and Dependents of the Employee, (as defined in the Eligibility Section), who are enrolled for coverage under this plan.

NEW MEMBER - shall mean a Member who requires treatment for an Acute Condition within the first thirty (30) days after the date he or she becomes eligible for benefits.

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

SPECIALIST SERVICES - shall mean services performed by a dentist who specializes in a particular type of dental care (i.e., the practice of oral surgery, endodontics, periodontics or pediatric dentistry) and which must be preauthorized in writing by PMI.

TREATMENT PLAN - shall mean the procedures developed by your Contract Dentist to provide dental care for a particular condition.

USUAL FEE means the fee that an individual dentist most frequently charges for a given dental service.

General Information

PMI is founded on the principle of delivering quality dental care and preventing dental problems before they start. Dental services are provided solely at PMI Contract Dental Offices. If any services are provided by a non-PMI Contract Dentist or specialist, you will be obligated to pay for such services.

How To Use Your Plan

When you enroll in the plan, PMI will assign you and your Dependents to a Contract Dentist near your home. You may select a different Contract Dentist or Contract Dental Group from the PMI list of participating providers. This list may be secured by calling PMI at the number on the back page of this booklet. You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three contract dental facilities.

If you decide to change Contract Dentists, you may call or write PMI as indicated on the back page of this booklet. The PMI Customer Service department will help you make the transfer which will become effective the first of the month following receipt of your request, if received by PMI at least five (5) working days prior to that date.

After you have enrolled, PMI will send you a membership packet which will provide your Contract Dentist's address and telephone number. You simply telephone for an appointment to receive necessary dental care covered by the plan. If you cannot keep your appointment, notify the Contract Dentist's office at least 24 hours in advance, or you will be charged for a broken appointment.

When you arrive at your Contract Dentist's office for your appointment, present your membership card. You will receive all necessary reasonable and customary care as listed in the Description of Benefits on pages 10 through 18. Work will be done according to a Treatment Plan carefully developed by your Contract Dentist.

To receive benefits, other than for out-of-area emergency dental care, service must be rendered by: your assigned PMI Contract Dentist; a dental hygienist under his/her supervision; or a specialist to whom your PMI Contract Dentist has referred you, and whose treatment has been authorized in writing by PMI.

If you have any questions about a prior authorization, please do not hesitate to call PMI at the numbers listed on the back page of this booklet.

If your assigned Contract Dentist's contract with PMI terminates, that Contract Dentist will complete (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. 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.

Emergency Services/Acute Condition

To obtain Emergency Services for relief of pain, you may call your PMI Contract Dentist for an emergency appointment.

In the event of an out-of-area dental emergency, PMI will pay dental expenses incurred up to a maximum of \$100 during any 12 month period, less any applicable Copayment. "Out-of-area" means 25 miles or more from your PMI Contract Dentist's facility. Any other treatment rendered by a non-PMI Contract Dentist is not covered under this plan.

If you have been enrolled less than thirty (30) days, and if you are currently experiencing an Acute Condition, contact PMI's Customer Service 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; and
- that PMI will reimburse you for the cost of such treatment up to a maximum of \$100 during any 12-month period; and
- that you must submit a claim within ninety (90) days after receiving the treatment; and
- that you or your Dependent must visit your Contract Dentist for treatment of that Acute Condition after that person has been eligible for benefits for 30 days.

Special Needs

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

If a Member believes he or she has a Special Health Care Need, the Member should contact PMI's Customer Service 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 Member 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 Service department at (800) 422-4234.

Provider Compensation

A Contract Dentist is compensated by PMI through monthly capitation (an amount based on the number of Members assigned to the Dentist), and by Members through required Copayments for treatment received. A Contract Specialist is compensated by PMI through an agreed-upon amount for each covered procedure, and by Members 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.

IN THE EVENT PMI FAILS TO PAY A CONTRACT DENTIST:

In the event that PMI fails to pay a Contract Dentist, the Member shall not be liable to the Contract Dentist for any sums owed by PMI.

DeltaCare provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by PMI.

IN THE EVENT PMI FAILS TO PAY A NON-CONTRACT DENTIST:

If you have not received preauthorization for treatment from a non-Contract Dentist, and PMI fails to pay that non-Contract Dentist, the member may be liable to that Dentist for the cost of services.

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.

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 a Member 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.

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 Service department at (800) 422-4234 for information regarding PMI's processing policies.

The Plan's dental guidelines, criteria and standards, as filed and reviewed by the California Department of Managed Health Care, are consistent with scientific literature and recognized expert sources, such as the Dental Board of California, Centers for Disease Control, National Institute of Health, Food and Drug Administration (FDA) and the American and California Dental Associations.

The Peer Review and Quality Management Committee is composed of the Dental Director and at least three contract general dentists and five contract dental specialists.

Claims for Reimbursement

Claims for Emergency Services or Specialist Services which are Benefits must be submitted to PMI within 90 days after completion of treatment. Failure to submit a claim within 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 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.

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, he or she may call PMI's Customer Service department at (800) 422-4234, or the complaint may be addressed in writing to:

PMI Quality Management Department
MS QM600
12898 Towne Center Drive
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 University and 4) the Dentist's name and facility location.

Within five calendar days of the receipt of any complaint, the quality management coordinator will forward to the complainant an acknowledgment of receipt of the complaint. Those complaints requiring professional expertise shall be referred to a licensed PMI dental consultant or dental director for review. Certain complaints may also 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 three 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 an 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 **(888) HMO-2219** and a TDD line **(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 an 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.

Prepayment of Premiums

This Program requires premiums to be paid to PMI. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction or you will be requested to pay it directly to PMI. The Group will be responsible for sending all payments of premiums to PMI except payments you are requested to pay directly.

Cancellation and Renewal

Benefits under this Plan will terminate upon the occurrence of any of the following: on the designated termination date provided by the Plan or the group to the other party by 60 days advance written notice, or at any time if the group fails to make applicable payments required by the contract; if the Member fails to make the required Copayments; the Plan is no longer legally able to provide services. Upon cancellation of the Plan, individual Members and their Dependents have no right to renewal or reinstatement.

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.

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 Members 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.

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 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 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 organization 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.

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 of the program. Please refer to *Schedule B* 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	MEMBER 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 radiographs - complete series (including bitewings) - limited to 1 series every 12 months	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical, each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing radiograph - single film	No Cost
D0272	Bitewings radiographs - two films	No Cost
D0274	Bitewings radiographs - four films - limited to 1 series every 6 months	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	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 cleaning - adult - 2 per 12 month period	No Cost
D1120	Prophylaxis cleaning - child - 2 per 12 month period	No Cost

Code	Description	MEMBER PAYS
D1201	Topical application of fluoride (including prophylaxis) - child - to age 19; 2 per 12 month period	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child - to age 19; 2 per 12 month period	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	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 maximum cost to the Enrollee of \$100.00 per tooth. If a cast post and core is made of high noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgraded post and core.*

² *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150.00.*

³ *Replacement is subject to a limitation requiring the existing restoration to be 3+ years old.*

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
D2391	Resin-based composite - one surface, posterior	\$ 65.00
D2392	Resin-based composite - two surfaces, posterior	\$ 75.00
D2393	Resin-based composite - three surfaces, posterior	\$ 85.00
D2394	Resin-based composite - four or more surfaces, posterior	\$ 95.00
D2510	Inlay - metallic - one surface ^{1,3}	No Cost
D2520	Inlay - metallic - two surfaces ^{1,3}	No Cost
D2530	Inlay - metallic - three or more surfaces ^{1,3}	No Cost
D2542	Onlay - metallic - two surfaces ^{1,3}	No Cost
D2543	Onlay - metallic - three surfaces ^{1,3}	No Cost
D2544	Onlay - metallic - four or more surfaces ^{1,3}	No Cost
D2610	Inlay - porcelain/ceramic - one surface	\$ 250.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$ 300.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$ 350.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$ 320.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$ 390.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$ 420.00

Code	Description	MEMBER PAYS
D2650	Inlay - resin-based composite - one surface	\$ 150.00
D2651	Inlay - resin-based composite - two surfaces	\$ 200.00
D2652	Inlay - resin-based composite - three or more surfaces	\$ 250.00
D2662	Onlay - resin-based composite - two surfaces	\$ 200.00
D2663	Onlay - resin-based composite - three surfaces	\$ 250.00
D2664	Onlay - resin-based composite - four or more surfaces	\$ 300.00
D2710	Crown - resin (indirect) ^{2,3}	\$ 50.00
D2720	Crown - resin with high noble metal ^{1,2,3}	\$ 50.00
D2721	Crown - resin with predominantly base metal ^{2,3}	\$ 50.00
D2722	Crown - resin with noble metal ^{2,3}	\$ 50.00
D2740	Crown - porcelain/ceramic substrate ^{2,3}	\$ 50.00
D2750	Crown - porcelain fused to high noble metal ^{1,2,3}	\$ 50.00
D2751	Crown - porcelain fused to predominantly base metal ^{2,3}	\$ 50.00
D2752	Crown - porcelain fused to noble metal ^{2,3}	\$ 50.00
D2780	Crown - ¾ cast high noble metal ^{1,3}	\$ 50.00
D2781	Crown - ¾ cast predominantly base metal ³	\$ 50.00
D2782	Crown - ¾ cast noble metal ³	\$ 50.00
D2790	Crown - full cast high noble metal ^{1,3}	\$ 50.00
D2791	Crown - full cast predominantly base metal ³	\$ 50.00
D2792	Crown - full cast noble metal ³	\$ 50.00
D2910	Recement inlay	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - anterior primary tooth	No Cost
D2933	Prefabricated stainless steel crown with resin window - anterior primary 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
D2970	Temporary crown (fractured tooth) - palliative treatment only	No Cost
D2980	Crown repair, by report	No Cost

D3000-D3999 IV. Endodontics

⁴ A benefit for permanent teeth only.

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

Code	Description	MEMBER PAYS
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - anterior (excluding final restoration) ⁴	\$ 20.00
D3320	Root canal - bicuspid (excluding final restoration) ⁴	\$ 40.00
D3330	Root canal - molar (excluding final restoration) ⁴	\$ 60.00
D3346	Retreatment of previous root canal therapy - anterior ⁴	\$ 20.00
D3347	Retreatment of previous root canal therapy - bicuspid ⁴	\$ 40.00
D3348	Retreatment of previous root canal therapy - molar ⁴	\$ 60.00
D3410	Apicoectomy/periradicular surgery - anterior ⁴	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) ⁴	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root) ⁴	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root) ⁴	No Cost
D3430	Retrograde filling - per root ⁴	No Cost
D3450	Root amputation, per root - not covered in conjunction with procedure D3920 ⁴	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	\$ 100.00
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	\$ 100.00
D4270	Pedicle soft tissue graft procedure	\$ 150.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$ 150.00
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to 5 quadrants during any 12 consecutive months	No Cost
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant - limited to 5 quadrants during any 12 consecutive months	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months	No Cost
D4910	Periodontal maintenance - limited to 1 treatment each 6 month period	No Cost

Code	Description	MEMBER PAYS
D5000-D5899	VI. Prosthodontics (removable)	
⁵	<i>Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.</i>	
⁶	<i>Limited to 1 per denture during any 12 consecutive months.</i>	
⁷	<i>Replacement is subject to a limitation requiring the existing denture to be 3+ years old.</i>	
D5110	Complete denture - maxillary ^{5,7}	\$ 65.00
D5120	Complete denture - mandibular ^{5,7}	\$ 65.00
D5130	Immediate denture - maxillary ^{5,7}	\$ 65.00
D5140	Immediate denture - mandibular ^{5,7}	\$ 65.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ^{5,7}	\$ 65.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ^{5,7}	\$ 65.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{5,7}	\$ 65.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{5,7}	\$ 65.00
D5410	Adjust complete denture - maxillary ⁵	No Cost
D5411	Adjust complete denture - mandibular ⁵	No Cost
D5421	Adjust partial denture - maxillary ⁵	No Cost
D5422	Adjust partial denture - mandibular ⁵	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 ⁶	\$ 20.00
D5711	Rebase complete mandibular denture ⁶	\$ 20.00
D5720	Rebase maxillary partial denture ⁶	\$ 20.00
D5721	Rebase mandibular partial denture ⁶	\$ 20.00
D5730	Reline complete maxillary denture (chairside) ⁶	No Cost
D5731	Reline complete mandibular denture (chairside) ⁶	No Cost
D5740	Reline maxillary partial denture (chairside) ⁶	No Cost
D5741	Reline mandibular partial denture (chairside) ⁶	No Cost
D5750	Reline complete maxillary denture (laboratory) ⁶	No Cost
D5751	Reline complete mandibular denture (laboratory) ⁶	No Cost
D5760	Reline maxillary partial denture (laboratory) ⁶	No Cost
D5761	Reline mandibular partial denture (laboratory) ⁶	No Cost
D5820	Interim partial denture (maxillary) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing ⁵	No Cost

Code	Description	MEMBER PAYS
D5821	Interim partial denture (mandibular) - limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing ⁵	No Cost
D5850	Tissue conditioning, maxillary ^{5,6}	No Cost
D5851	Tissue conditioning, mandibular ^{5,6}	No Cost
D5900-D5999	VII. Maxillofacial Prosthetics - Not Covered	
D6000-D6199	VIII. Implant Services	Optional
[*]	<i>Optional is defined as 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 the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. "Filed fees" mean the Contract Dentist's fees on file with PMI. Questions regarding the DeltaCare program should be directed to PMI's Customer Service department at (800) 422-4234.</i>	
	Optional implant services [*]	Subject to Limitation #31
D6200-D6999	IX. Prosthodontics, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]).	
¹	<i>Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of \$100.00 per tooth. If a cast post and core is made of high noble metal, an additional fee up to \$100.00 per tooth will be charged for the upgraded post and core.</i>	
²	<i>Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150.00.</i>	
⁸	<i>Replacement is subject to a limitation requiring the existing bridge to be 3+ years old.</i>	
D6210	Pontic - cast high noble metal ^{1,8}	\$ 50.00
D6211	Pontic - cast predominantly base metal ⁸	\$ 50.00
D6212	Pontic - cast noble metal ⁸	\$ 50.00
D6240	Pontic - porcelain fused to high noble metal ^{1,2,8}	\$ 50.00
D6241	Pontic - porcelain fused to predominantly base metal ^{2,8}	\$ 50.00
D6242	Pontic - porcelain fused to noble metal ^{2,8}	\$ 50.00
D6245	Pontic - porcelain/ceramic ^{2,8}	\$ 50.00
D6250	Pontic - resin with high noble metal ^{1,2,8}	\$ 50.00
D6251	Pontic - resin with predominantly base metal ^{2,8}	\$ 50.00
D6252	Pontic - resin with noble metal ^{2,8}	\$ 50.00
D6600	Inlay - porcelain/ceramic, two surfaces ⁸	\$ 300.00
D6601	Inlay - porcelain/ceramic, three or more surfaces ⁸	\$ 350.00
D6602	Inlay - cast high noble metal, two surfaces ^{1,8}	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces ^{1,8}	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces ⁸	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces ⁸	No Cost
D6606	Inlay - cast noble metal, two surfaces ⁸	No Cost
D6607	Inlay - cast noble metal, three or more surfaces ⁸	No Cost

Code	Description	MEMBER PAYS
D6608	Onlay - porcelain/ceramic, two surfaces ⁸	\$ 320.00
D6609	Onlay - porcelain/ceramic, three or more surfaces ⁸	\$ 420.00
D6610	Onlay - cast high noble metal, two surfaces ^{1,8}	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces ^{1,8}	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces ⁸	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces ⁸ ...	No Cost
D6614	Onlay - cast noble metal, two surfaces ⁸	No Cost
D6615	Onlay - cast noble metal, three or more surfaces ⁸	No Cost
D6720	Crown - resin with high noble metal ^{1,2,8}	\$ 50.00
D6721	Crown - resin with predominantly base metal ^{2,8}	\$ 50.00
D6722	Crown - resin with noble metal ^{2,8}	\$ 50.00
D6740	Crown - porcelain/ceramic ^{2,8}	\$ 50.00
D6750	Crown - porcelain fused to high noble metal ^{1,2,8}	\$ 50.00
D6751	Crown - porcelain fused to predominantly base metal ^{2,8}	\$ 50.00
D6752	Crown - porcelain fused to noble metal ^{2,8}	\$ 50.00
D6780	Crown - ¾ cast high noble metal ^{1,8}	\$ 50.00
D6781	Crown - ¾ cast predominantly base metal ⁸	\$ 50.00
D6782	Crown - ¾ cast noble metal ⁸	\$ 50.00
D6790	Crown - full cast high noble metal ^{1,8}	\$ 50.00
D6791	Crown - full cast predominantly base metal ⁸	\$ 50.00
D6792	Crown - full cast noble metal ⁸	\$ 50.00
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker ⁸	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
D6980	Fixed partial denture repair, by report	No Cost
D7000-D7999 X. Oral and Maxillofacial Surgery		
<i>Includes preoperative and postoperative evaluations and treatment under local anesthetic.</i>		
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	\$ 15.00
D7230	Removal of impacted tooth - partially bony	\$ 15.00
D7240	Removal of impacted tooth - completely bony	\$ 15.00

Code	Description	MEMBER PAYS
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$ 15.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7286	Biopsy of oral tissue - soft (all others) - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	No Cost
D7410	Excision of benign lesion up to 1.25 cm	No Cost
D7411	Excision of benign lesion greater than 1.25 cm	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 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
D7880	Occlusal orthotic device, by report - <i>occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction</i>	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost

D8000-D8999 XI. Orthodontics

⁹ Listed Copayment covers up to 36 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee". Beyond 36 months of active treatment, an additional monthly fee of \$75.00 applies.

¹⁰ 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.

¹¹ Includes adjustments and/or office visits up to 36 months. After 36 months, a monthly fee of \$75.00 applies.

D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 ⁹	\$1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19 ⁹	\$1000.00
D8090	Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adults ⁹	\$1000.00
D8660	Pre-orthodontic treatment visit - <i>not to be charged with any other consultation procedure(s)</i> ¹⁰	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) ¹¹	No Cost
D8999	Unspecified orthodontic procedure, by report - includes START UP FEES (including initial examination, diagnosis, consultation and initial banding)	No Cost

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
D9221	Deep sedation/general anesthesia - each additional 15 minutes - for extractions only and only when medically necessary	No Cost
D9241	Intravenous conscious sedation/analgesia - first 30 minutes - for extractions only and only when medically necessary	No Cost
D9242	Intravenous conscious sedation/analgesia, each additional 15 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	\$ 20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9940	Occlusal guard, by report - <i>occlusal orthotic device and guards are a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction</i>	No Cost
D9951	Occlusal adjustment - limited - <i>a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction</i>	No Cost
D9952	Occlusal adjustment - complete- <i>a covered benefit only for the treatment of temporomandibular joint (TMJ) dysfunction</i>	No Cost
D9972	External bleaching - per arch	\$ 175.00
D9999	Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice - per 15 minutes of appointment time	\$ 10.00

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 Service department at (800) 422-4234.

**SCHEDULE B
LIMITATIONS OF BENEFITS**

1. Full mouth x-rays are limited to one set every 12 consecutive months and include any combination of periapicals, bitewings and/or panoramic film;
2. Bitewing x-rays are limited to not more than one series of four films in any six month period;
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits;
4. If a biopsy is prior approved by PMI to an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473 or D0474 and available at no additional cost;
5. Prophylaxis or periodontal maintenance is limited to two procedures each 12 month period;
6. Benefits for sealants 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 through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application;
7. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling;
8. A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non functional or non restorable and meets the three year limitation (Limitation #12);
9. A covered metallic inlay, onlay, crown or fixed partial denture (bridge) using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is \$100.00 per tooth or pontic. For a cast post and core, the benefit is for base or noble metal. If the Enrollee elects to have a high noble metal cast post and core instead, the maximum additional cost of this material upgrade is \$100.00 per tooth;
10. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is \$150.00 per molar for those procedures indicated with footnote ²;
11. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is \$75.00;

12. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
 - a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
 - b. Either of the following:
 - The existing non-functional restoration/bridge/denture was placed three or more years prior to its replacement, **or**
 - If an existing partial denture is less than three years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture;
13. A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth;
14. With the exception of pulp caps and pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth;
15. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy;
16. Periodontal scaling and root planing are limited to five quadrants during any 12 month period;
17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period;
18. 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.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, it is considered Optional treatment.

Replacement of an existing nonfunctional bridge is limited to once in a three year period 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.

Optional treatment procedures are defined under Limitation #27.

19. Relines, tissue conditioning and rebases are limited to one per denture during any 12 consecutive months;
20. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
 - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture; **or**
 - The replacement of permanent tooth/teeth for children under 16 years of age;
21. Retained primary teeth shall be covered as primary teeth;
22. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance;
23. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by PMI, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
24. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits*;
25. Soft tissue management programs are limited to periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter the benefit for other covered services;
26. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered;
27. An Optional procedure is defined as 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 the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fees" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits.
28. General anesthesia/IV sedation and the services of a special anesthesiologist, except for extractions only and only when medically necessary as determined by a physician. The following four types of extractions may be approved for coverage of general anesthesia/IV sedation: 1) uncomplicated (the tooth can be seen),

2) surgical removal (only the top of the tooth can be seen), 3) partially bony (part of the tooth is attached to the bone), and 4) complete bony (the tooth is completely attached to the bone). A written authorization from a physician is necessary for coverage of general anesthesia/IV sedation, which PMI must approve prior to referral to an Oral Surgeon;

29. The Contract Dentist shall have the right to refuse treatment to an Enrollee who continually fails to follow a prescribed course of treatment.
30. Pedicle soft tissue grafting is covered on a per tooth basis and includes split-thickness grafts, three months post-operative care, any surgical reentry within a three year period, and any frenectomy and/or distal wedge performed in the same area on the same date. Exceptional cases will be given consideration on a by report basis. When procedure is performed as purely cosmetic dentistry, it is not a covered Benefit and is considered Optional.

Free soft tissue grafting (including donor site) is covered on a per tooth basis and includes subepithelial connective tissue grafts, three months post-operative care, any surgical reentry within a three year period and any frenectomy and/or distal wedge performed in the same area on the same date. Exceptional cases will be given consideration on a by report basis. When procedure is performed as purely cosmetic dentistry, it is not a Benefit and is considered Optional. The procedure is appropriate only when not performed in conjunction with any other periodontal services in the same area. When other periodontal services are involved, this service is considered to be part of and included in the fee for the more inclusive procedure.

31. If implants are utilized, PMI will allow the cost of a standard full or partial denture toward the cost of implants and appliances constructed thereon (Optional treatment formula). The patient is responsible for the Optional treatment fee if implants are used. The PMI Plan will not pay for the surgical removal of implants.
32. External bleaching is limited to fabrication of one bleaching tray per arch; bleaching gel for two weeks of patient self treatment and no more than one treatment per arch, per 36 months.

“Filed fee” means the Contract Dentist’s fees on file with PMI. Questions regarding these fees should be directed to PMI’s Customer Service department at (800) 422-4234.

EXCLUSIONS OF BENEFITS

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*;
2. Dental conditions arising out of and due to Enrollee’s employment for which Worker’s Compensation is paid. Services that 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. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges);
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage;
6. Dental expenses incurred in connection with any dental procedure started before the Enrollee’s eligibility with the DeltaCare program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics;
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) except for the treatment of newborn children with congenital defects or birth abnormalities;
8. Dispensing of drugs not normally supplied in a dental facility;
9. Any procedure that in the professional opinion of the Contract Dentist or PMI’s dental consultant:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry;
10. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by PMI or as cited under Provisions for Emergency Care. To obtain written authorization, the Enrollee should call PMI’s Customer Service department at (800) 422-4234;
 11. Consultations for non-covered benefits;
 12. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age;
 13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
 14. 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), other than occlusal guard, occlusal adjustment and occlusal orthotic devices as presented in Schedule A, Description of Benefits and Copayments;

15. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered benefits. This exclusion does not eliminate the benefit for other covered services;
16. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures;
17. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions;
18. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent;
19. Services and benefits provided by the Employee, or any eligible family member, or by the spouse, child, brother, sister, parent, or other relative of the Employee, spouse, or other dependents;
20. Replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or better match bleached teeth.

TEMPOROMANDIBULAR JOINT BENEFIT

PMI will pay 100% of the Dentist's Usual Fees or of the fees actually charged for all covered temporomandibular joint (TMJ) procedures, as noted herein. TMJ benefits are intended only for the treatment of temporomandibular (jaw) joint and are limited to the procedures noted below when provided by a licensed dentist as necessary and customary according to the standards of generally accepted dental practice and only when provided for the treatment of TMJ dysfunction:

- D7880 Occlusal orthotic device, by report
- D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
- D9940 Occlusal guard, by report
- D9951 Occlusal adjustment - limited
- D9952 Occlusal adjustment - complete

Limitations and Exclusions of TMJ Benefits

TMJ benefits are subject to Schedule B, Limitations and Exclusions of Benefits, and any definitions and/or other terms of the DeltaCare Group Dental Service Contract not in conflict with the express terms of this benefit in addition to the following:

1. The replacement of lost, missing or stolen appliances furnished in whole or in part under this benefit or any other TMJ benefit are not covered.
2. Repair and replacement of covered TMJ devices may be made only after three years have elapsed following any prior provision of such appliances under this program or any other program, except when it is determined that there is such extensive change in the patient's condition (such as the loss of a tooth or teeth) that the appliance cannot be made functional. If the TMJ device is not functional resulting from abuse or alteration by the enrollee, this benefit is excluded.
3. Fixed appliances and restorations provided solely for the treatment of TMJ are excluded.
4. Diagnostic procedures not otherwise covered under the Group Dental Service Contract are excluded.
5. Services for bruxism (grinding of teeth) unrelated to TMJ dysfunction are not covered.

ORTHODONTIC LIMITATIONS

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

1. Orthodontic treatment must be provided by the Contract Orthodontist;
2. Benefits cover 36 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 36 months of active treatment, de banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of three years;
3. Treatment plans extending beyond 36 months of active treatment, or 36 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed \$75.00 per month;
4. 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 any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$1,400.00 and prorated 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;

Should this Contract be terminated by either party due to breach or non-renewal at the end of any applicable term, the provision of Paragraph C above shall apply with respect to an Enrollee being treated for orthodontic work which is not completed at the date of termination. The Enrollee's payment shall be no more than \$1,000.00.

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 \$25.00 in addition to diagnostic record fees;
6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee;
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 amounts as for fixed appliances.

ORTHODONTIC EXCLUSIONS

1. Lost, stolen or broken orthodontic appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely used in typical comprehensive orthodontics;
9. Restorative work caused by orthodontic treatment;
10. Phase I orthodontics¹², as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;

12. Treatment in progress at inception of eligibility;
 13. Transfer after banding has been initiated;
 14. Composite bands, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- ¹² Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

ACCIDENT INJURY BENEFIT

An accident injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under Schedule A, Description of Benefits and Copayments.

PMI will pay up to 100% of the Contract Dentist's "filed fees", for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s).

Accident injury benefits include the following procedure in addition to those listed in Schedule A, Description of Benefits and Copayments.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to Schedule B, Limitations and Exclusions of Benefits.

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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 Service and the Online Customer Service Request for DeltaCare (administered by PMI).