PRIVATE MEDICAL-CARE, INC.
12898 Towne Center Drive, Cerritos, California 90703
(562) 924-8311 (800) 801-7105

APPLICATION FOR DeltaCare USA GROUP DENTAL SERVICE CONTRACT

The undersigned group County of San Mateo ("County") hereby applies for a DeltaCare USA GROUP DENTAL SERVICE CONTRACT with PRIVATE MEDICAL-CARE, INC. ("PMI") on the following terms:

I. County hereby authorizes PMI to furnish the dental Benefits described in the attached Contract, subject to all of the terms and conditions of the Contract.

II. County or Enrollees agree to pay to PMI, in advance, the Premiums specified in Schedule C to the Contract.

III. Upon acceptance of this Application by PMI, and payment of the initial Premiums, the Contract shall be effective at 12:01 a.m. on the Effective Date shown on Schedule C and the Contract shall continue until terminated as provided.

IV. County agrees to make available to Eligible Employees or Enrollees any notices concerning Benefits required to be furnished by PMI.

V. **PMI will provide directly to each Eligible Person or Enrollee a combined Evidence of Coverage and Disclosure Form (EOC). PMI's Enrollment materials advise Eligible Persons that an EOC is also available upon request, prior to enrollment by contacting PMI's Customer Relations department. The EOC will disclose the terms and conditions of coverage, but will constitute only a summary of the program. As required by the California Health & Safety Code, the Contract must be consulted to determine the exact terms and conditions of the coverage provided. A copy of the Contract will be furnished upon request. Enrollees should read the EOC carefully. Persons with special healthcare needs should read the section entitled "Special Needs". Pursuant to California Health and Safety Code, the EOC provides Enrollees with information regarding the societal benefits of organ donation and the method whereby an Enrollee may elect to be an organ or tissue donor. Enrollees may also obtain information about Benefits by calling PMI's Customer Relations department at (800) 422-4234.**

VI. County agrees to receive, on behalf of Enrollees, all applicable notices concerning Benefits under this Contract.

VII. THE PREMIUMS PAYABLE UNDER THIS CONTRACT ARE SUBJECT TO INCREASE UPON RENEWAL AFTER THE END OF THE INITIAL CONTRACT TERM OR ANY SUBSEQUENT CONTRACT TERM.

_____
(Date)

See Appendix A
(Group Number)

County of San Mateo
(County)

455 County Center, Redwood City, CA 94063-1663
(County Address)

By: _____ By: _____
(Authorized Signature) (Licensed Registered Agent)

PRIVATE MEDICAL-CARE, INC.
12898 Towne Center Drive, Cerritos, California 90703
(562) 924-8311 (800) 801-7105

DeltaCare USA GROUP DENTAL SERVICE CONTRACT

IN CONSIDERATION of the Application, a copy of which is attached hereto and made a part of this DeltaCare USA GROUP DENTAL SERVICE CONTRACT ("Contract") and IN CONSIDERATION of payment of the required Premiums, PRIVATE MEDICAL-CARE, INC. ("PMI") agrees to provide the Benefits described for the Contract Term shown on Schedule C and from year to year thereafter, unless this Contract is terminated as provided. Premiums are payable in advance of the Effective Date and thereafter as provided. This Contract is issued and delivered in the State of California, is governed by the laws thereof, and is subject to the terms and conditions recited on the following pages.

IN WITNESS WHEREOF, PMI has caused this Contract to be executed on:

Date: August 23, 2006

PRIVATE MEDICAL-CARE, INC.

By: Marilyn Masters

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ARTICLE 1. DEFINITIONS

For the purpose of this Contract, the following definitions shall apply:

1.01 "Acute Condition" means a condition requiring Emergency Services while a New Enrollee is within thirty-five (35) miles from the facility of the assigned Contract Dentist.

1.02 "Benefits" mean those dental services which are provided under the terms of this Contract as specified in Article 4 and Schedule A.

1.03 "Contract" means this agreement between PMI and County including the Application for this Contract, the attached schedules, and any appendices, endorsements or riders. This Contract constitutes the entire agreement between the parties.

1.04 "Contract Dentist" means a Dentist who provides services in general dentistry and who has contracted with PMI to provide Benefits to Enrollees under this Contract.

1.05 "Contract Orthodontist" means a Dentist who specializes in orthodontics, and who has contracted with PMI to provide Benefits to Enrollees under this Contract.

1.06 "Contract Specialist" means a Dentist who provides Specialist Services and has contracted with PMI to provide Benefits to Enrollees under this Contract.

1.07 "Contract Term" means the period commencing and terminating on the dates shown on Schedule C, and each yearly period thereafter during which this Contract remains in effect.

1.08 "Copayment" means the amount charged to an Enrollee by a Dentist for the Benefits provided under this Contract.

1.09 "County of San Mateo" ("County") means the Employer contracting to obtain dental benefits.

1.10 "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.

1.11 "Domestic Partner" means a person who, together with the Eligible Employee, has filed a Statement of Domestic Partnership with the County. The Eligible Persons are not related by blood closer than would bar marriage in the State of California; neither person is married to another or related by marriage to each other; they share the common necessities of life; are eighteen (18) years of age or older; and declare that they are each other's sole Domestic Partner and that neither has a different Domestic Partner. The Eligible Persons agree to notify the County of any change in the status of their domestic partnership.

1.12 "Effective Date" means the date this Contract becomes effective as provided in Schedule C.

1.13 "Eligibility Date" means the date upon which an Eligible Person's eligibility for Benefits becomes effective under this Contract.

1.14 "Eligible Employee" means any employee or member of County who meets the conditions of eligibility outlined in Article 2.

1.15 "Eligible Dependent" means any of the dependents of an Eligible Employee who are eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in Article 2.

1.16 "Eligible Person" means an Eligible Employee or Eligible Dependent.

1.17 "Emergency Services" 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.

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

1.19 "New Enrollee" means an Enrollee who is enrolled less than thirty (30) days from the date he or she is eligible for Benefits.

1.20 "Open Enrollment Period" means the period preceding the date of commencement of the Contract Term or the 30-day period immediately preceding the annual anniversary of the commencement of the Contract Term or a period as otherwise requested by the County and agreed to by PMI.

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

1.22 "Premiums" mean amounts payable by County or an Enrollee as provided in Article 3 and Schedule C.

1.23 "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 (i) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and (ii) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

1.24 "Specialist Services" mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, pediatric dentistry or periodontics and which must be preauthorized in writing by PMI.

ARTICLE 2. ELIGIBILITY, ENROLLMENT AND CANCELLATION OF ENROLLMENT

2.01 Eligible Employees are those employees or group members described in Schedule C. New employees shall become eligible for coverage as specified in Schedule C.

Eligible Dependents of an Eligible Employee are spouse (unless legally separated or divorced), Domestic Partner (regardless of gender) who together with the Eligible Employee has affirmed a Domestic Partnership through the County, until such partnership is terminated by either or both parties, and unmarried dependent children from birth to age 19, or to age 30 if Employee provides fifty-percent of financial support. Children include step-children, adopted children, foster children and children of Domestic Partner, provided such children are dependent upon the employee for support and maintenance. Dependents become eligible coincident with the Eligible Employee, upon attainment of dependent status, or at any time subject to a change in legal custody or lawful order to provide Benefits. Newborn infants are eligible from and after the moment of birth. 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 19 years or over may continue to be eligible as a dependent if incapable of self-support because of physical or mental disability that commenced prior to reaching age 30 if Employee provides fifty-percent of financial support, provided proof of such disability and dependency is submitted not less than 31 days prior to the dependent's attainment of the limiting age, and subsequently as may be required by either PMI or County, but not more frequently than annually after the disabled and dependent child has attained the limiting age.

Dependents in military service are not eligible. No one may be an Eligible Dependent if eligible as an Eligible Employee and no one may be an Eligible Dependent of more than one Eligible Employee.

Medicare eligibility shall not affect eligibility of an Eligible Employee or Eligible Dependent.

2.02 Eligible Employees must complete and sign enrollment forms provided by PMI during the Open Enrollment Period in order to receive Benefits and for their Eligible Dependents to receive Benefits. Persons not originally eligible during the Open Enrollment Period may be enrolled immediately upon attainment of dependent status or at any time subject to a change in legal custody or lawful order to provide Benefits. Subject to cancellation as provided under this Contract, enrollment of Eligible Employees and any Eligible Dependents is for a minimum period of one year.

County shall compile and furnish to PMI on or prior to the first day of every month, a list of all Primary Enrollees showing their Social Security numbers and, if applicable, location codes and all Dependent Enrollees. PMI shall be obligated to provide Benefits only to Primary Enrollees and their Dependent Enrollees who are enrolled and are reported on the list of Primary Enrollees submitted by County and for whom the appropriate Premiums are paid pursuant to Article 3 and Schedule C of this Contract for the period in which covered dental services are provided. Newborn infants are covered from the moment of birth up to 31 days, and thereafter if notification of birth and the appropriate Premiums are received by PMI within 31 days after the date of birth.

2.03 Subject to any rights provided under Article 6, enrollment under this Contract may be cancelled, or renewal of enrollment refused, in the following events:

a) Upon 30 days' notice if the Contract is terminated or not renewed.

b) Immediately upon loss of eligibility.

c) Upon 15 days' written notice if the Premiums are not paid by or on behalf of the Enrollee on the date due. However, the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Contract upon payment of any unpaid Premiums.

d) Immediately if the Enrollee is guilty of misconduct detrimental to the delivery of services while in the facility of a Contract Dentist.

e) Upon 15 days' written notice if the Enrollee knowingly perpetrates or permits another person to perpetrate fraud or deception in obtaining Benefits under this Contract.

f) Upon 30 days' written notice if the Enrollee fails to pay Copayments; provided, however, that the Enrollee may be reinstated during the term of this Contract upon payment of all delinquent charges.

g) Upon 30 days' written notice, if (i) the Enrollee and a Contract Dentist fail to establish a satisfactory patient-Dentist relationship, (ii) it is shown that PMI has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist, (iii) the Enrollee has been notified in writing at least 30 days in advance that PMI considers the patient-Dentist relationship to be unsatisfactory and PMI specifies the changes that are necessary in order to avoid cancellation, and (iv) the Enrollee has failed to make such changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

2.04 An Enrollee who believes that enrollment has been cancelled or not renewed because of the Enrollee's health status or requirements for health care services, may request a review by the Director of the California Department of Managed Health Care in accordance with Section 1365(b) of the California Health and Safety Code.

ARTICLE 3. PREMIUMS AND COPAYMENTS

3.01 In accordance with Schedule C, County agrees to collect Premiums by means of payroll deductions for Primary Enrollees and Dependent Enrollees voluntarily enrolled for Benefits under this Contract. County shall remit one check each period as required by Schedule C. Premiums which are not payroll deducted shall be paid directly to PMI by Primary Enrollees as required by Schedule C. Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee shall be re-enrolled.

3.02 This Contract shall not be in effect until initial Premiums are received. Subsequent Premiums shall be payable in accordance with Schedule C.

3.03 PMI may change the amount of Premiums whenever the terms of this Contract are changed by amendment or PMI's liability is changed by law or regulation. However, in the absence of an amendment mutually agreed upon between County and PMI or such a change in liability, no change in the Premiums shall become effective within a Contract Term except as provided in Section 3.04.

3.04 If during a Contract Term, any new tax is imposed on PMI by any government agency on the amount of Premiums payable under this Contract or the number of the persons covered, or if the rate of an existing tax on the amount of Premiums or the number of persons covered is increased, the Premiums stated in Schedule C shall be increased by the amount of any such new tax or increased taxes upon 30 days' written notice.

3.05 Upon discovery of clerical errors made by PMI with respect to enrollment data for a Primary Enrollee, Premiums may be adjusted back to the Primary Enrollee's Enrollment Date. The amount of credit which may be taken with respect to a Primary Enrollee shall not exceed the Premiums for the current month in which Premiums are due, plus two (2) months of retroactive Premiums. In addition, the total amount of credit which may be taken on any due date shall not exceed 10% of the billed amount for that due date.

3.06 Enrollees are required to pay any Copayments listed in the Description of Benefits and Copayments (attached as 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 emergency visits after normal visiting hours are shown on Schedule A.

3.07 In the event of cancellation of enrollment by PMI (except in the case of fraud or deception in obtaining Benefits from PMI or knowingly permitting such fraud or deception by another), PMI shall return to County the pro rata portion of the Premiums paid to PMI which corresponds to any unexpired period for which payment had been received, together with any amounts due on claims, if any, less any amounts owed to PMI.

ARTICLE 4. BENEFITS, LIMITATIONS AND EXCLUSIONS

4.01 PMI shall provide the Benefits in Schedule A, subject to the Limitations and Exclusions in Schedule B. Benefits are available to each Enrollee on the Eligibility Date.

4.02 PMI shall provide Contract Dentists at convenient locations during the term of this Contract. A list of Contract Dentists shall be furnished to all Primary Enrollees. Enrollees may select any Contract Dentist whose name is on said list at the time of enrollment. Enrollees in the same family may collectively select no more than three Contract Dentist facilities. If an Enrollee fails to select a Contract Dentist or the Contract Dentist selected becomes unavailable, PMI shall request the selection of another Contract Dentist or shall assign that Enrollee to another Contract Dentist. An Enrollee may make a change to any other Contract Dentist during the open enrollment period. Upon the approval of PMI, an Enrollee may select another Contract Dentist if the Enrollee has a change in family status or residence or fails to establish a satisfactory patient/doctor relationship with the Contract Dentist. The change must be requested prior to the 21st of the month to become effective on the first day of the following month.

4.03 The services which are Benefits shall be rendered by Contract Dentists, and PMI shall have no obligation or liability with respect to services rendered by non-Contract Dentists, with the exception of Emergency Services as provided in Section 4.04, or Specialist Services recommended by a Contract Dentist, and approved in writing by PMI. All services other than Emergency Services or Specialist Services shall be rendered at the facility of the Contract Dentist. Referral of Specialist Services must be by a Contract Dentist and must be authorized in writing by PMI. All approved Specialist Services claims will be paid by PMI less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. 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.

4.04 If an Enrollee is more than 35 miles from the facility of the assigned Contract Dentist, and requires Emergency Services, PMI shall reimburse the Enrollee for the cost of such treatment, less any applicable Copayments, up to a maximum of $100.00 during any 12-month period upon submission to PMI of a verifiable claim within 90 days after such treatment is received.

If an Enrollee has been enrolled less than 30 days, and if the Enrollee is currently experiencing an Acute Condition, he or she should contact PMI's Customer Relations department at (800) 422-4234 for authorization for treatment of the condition.

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

a) to seek treatment immediately necessary to alleviate severe pain, swelling or bleeding, or immediately necessary to avoid placing his or her health in serious jeopardy;

b) that treatment for an Acute Condition does not include any services other than Emergency Services;

c) that PMI will reimburse the Enrollee for the cost of such treatment up to a maximum of $100.00 during any 12-month period;

d) that the Enrollee must submit a claim within 90 days after receiving the treatment; and

e) that the Enrollee must visit his or her Contract Dentist for further treatment.

PMI may require a non-Contract Dentist providing treatment to an Enrollee 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.

4.05 In the event that PMI fails to pay a Contract Dentist, the Enrollee shall not be liable to that Dentist for any sums owed by PMI. In the event that PMI fails to pay a Dentist who is not a Contract Dentist, the Enrollee may be liable to that Dentist for the cost of services.

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

PMI shall acknowledge receipt of a claim within 20 working days unless payment of the claim is made within that time. Within 30 working days after receipt of a claim, PMI shall accept or deny the claim, in whole or in part, unless more time is required to determine whether the claim should be accepted or denied. If more time is required, PMI shall notify the Dentist within 30 working days of receipt of the claim of the reasons more time is required. PMI shall notify the Dentist again 45 days thereafter of the reasons any additional time is required to determine whether the claim should be accepted or denied.

4.07 Upon termination of a contract with a Contract Dentist, PMI shall be liable for Benefits rendered by such Contract Dentist to an Enrollee who is under the care of such Dentist at the time of such termination until any single procedure commenced prior to termination by such Dentist is completed, unless PMI makes reasonable and medically appropriate provisions for the completion of such procedure by another Contract Dentist. PMI shall give written notice to County within a reasonable time of any termination or breach of contract by, or inability to perform of, any Contract Dentist if County will be materially and adversely affected.

If an Enrollee's assigned Network Dentist's contract with PMI terminates, that Network 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.)

4.08 In the absence of an amendment mutually agreed upon between County and PMI, no change in Benefits shall be made during a Contract Term.

4.09 All Benefits shall terminate for any Enrollee as of the date that this Contract is terminated, such person ceases to be eligible under the terms of this Contract, or such person's enrollment is cancelled under this Contract. PMI shall not be obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Contract was in effect.

4.10 A Contract Dentist is compensated by PMI through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by PMI through an agreed-upon amount for each covered procedure, and by Enrollees through applicable Copayments. **In no event does PMI pay a Dentist or a Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment. An Enrollee may obtain further information concerning compensation of providers by calling PMI at (800) 422-4234.**

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

4.12 An Enrollee may request a second opinion if he or she disagrees with or questions the diagnosis and/or treatment plan determination made by his or her Contract Dentist. PMI may also request that an Enrollee obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be 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, the Enrollee should contact PMI's Customer Relations department at (800) 422-4234 or write to PMI. Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by PMI's dental consultant. PMI will only pay for a second opinion which PMI has approved or authorized.

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

ARTICLE 5. COORDINATION OF BENEFITS

5.01 This Contract 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 Contract are coordinated with such other group insurance policy or any group health benefits program.

5.02 When Benefits are coordinated with another group insurance policy or group health benefits program, the determination of which policy or program is primary shall be governed by the following rules:

a) The policy or program covering the patient as other than a dependent shall be primary over the policy or program covering the patient as a dependent.

b) The policy or program covering a child as a dependent of a parent whose birthday occurs earlier in a calendar year shall be primary over the policy or program covering a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in c) below).

c) In the case of a dependent child whose parents are legally separated or divorced:

1) If the parent with custody has not remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the parent without custody.

2) If the parent with custody has remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the step-parent, and the policy or program covering the child as a dependent of the step-parent shall be primary over the policy or program covering the child as a dependent of the parent without custody.

3) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this program, notwithstanding c) 1) and 2), the policy or program covering the child as a dependent of the parent with such financial responsibility shall be primary over any other policy or program covering the child.

d) If the primary policy or program cannot be determined by the rules described in a), b) or c), the policy or program which has covered the Enrollee for a longer period of time shall be primary, with the following exception: A policy or program covering the Enrollee as a laid-off or retired employee or the dependent of a laid-off or retired employee shall not be primary under this rule d) over a policy or program covering the Enrollee as an employee or the dependent of an employee. However, if the provisions of the other policy or program do not include this exception, which results in benefits under neither being primary, then this exception shall not apply.

5.03 An Enrollee shall 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 shall, 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 paid shall be deemed to be Benefits under this Contract. PMI shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as PMI chooses, the amount of any Benefits paid by PMI which exceed its obligations under these coordination of benefit provisions.

ARTICLE 6. ENROLLEE COMPLAINT PROCEDURE

6.01 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 an Enrollee has 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 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 County and 4) the Dentist's name and facility location.

6.02 For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must 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 the Enrollee 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 dental 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.

6.03 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 dental consultant for 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 imminent and serious threat to a patient's dental health.

6.04 If the Enrollee has completed PMI's grievance process, or he or she has been involved in PMI's grievance procedure for more than 30 days, he or she may file a complaint with the California Department of Managed Health Care. An Enrollee 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 the Enrollee's dental 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.

6.05 If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has 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, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

ARTICLE 7. GENERAL PROVISIONS

7.01 The Contract, the Contract application, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement between PMI and County. No agent has authority to amend this Contract or waive any of its provisions. No amendment to this Contract shall be valid unless approved by an executive officer of PMI and evidenced by endorsements.

7.02 If any portion of this Contract or any amendment thereof shall be determined by any arbitrator, court or other competent authority to be illegal, void or unenforceable, such determination shall not abrogate this Contract or any portion thereof other than such portion determined to be illegal, void or unenforceable, and all other portions of this Contract shall remain in full force and effect.

7.03 The parties agree that all questions regarding interpretation or enforcement of this Contract shall be governed by the laws of the State of California, where the Contract is entered into and is to be performed. PMI is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and of Chapter 1 of Division 1, of Title 28 of the California Code of Regulations. Any provisions required to be in the Contract by either of the above shall bind PMI whether or not provided in this Contract.

7.04 PMI will issue to the County for delivery to each Primary Enrollee an evidence of coverage summarizing the Benefits to which each Enrollee is entitled. If any amendment to this Contract shall materially affect any provisions described in such evidence of coverage, new evidences of coverage or riders showing the change shall be issued. Any direct conflict between the evidence of coverage and this Contract shall be resolved according to the terms most favorable to the Enrollee.

7.05 Both parties to this Contract agree to consult to the extent reasonably practical concerning all material published or distributed relating to this Contract. No such material shall be published or distributed which is contrary to the terms of this Contract.

7.06 County shall designate in writing a representative (Benefits Manager) for purposes of receiving notices from PMI under this Contract. County may change its representative at any time on 30 days' notice to PMI. Any notice under this Contract shall be sufficient if given by either County or PMI to the other addressed as stated on the Application of this Contract, and shall be effective 48 hours after deposit in the United States mail with postage fully prepaid. Any notice required from PMI to any Enrollee may be given to County's representative, who shall disseminate such notice to Enrollees by next regular communication but in no event later than 30 days after receipt thereof.

7.07 PMI shall be excused from performance under this Contract for any period and to the extent that it is prevented from performing any services in whole or in part as a result of an act of God, war, civil disturbance, strike, court order, or other cause beyond its reasonable control and which it could not have prevented by reasonable precautions.

7.08 Both parties to this Contract shall comply in all respects with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information. Both parties agree that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplification, security or privacy laws or regulations.

ARTICLE 8. TERMINATION AND RENEWAL

8.01 This Contract may be terminated by PMI upon County's failure (i) to furnish PMI with the eligibility list as required by Article 2, or (ii) to pay Premiums in the amount and manner required by Article 3, provided County has been notified of such failure and at least 15 days have elapsed since such notification.

8.02 Termination at the end of a Contract Term shall be by at least 30 days' advance written notice of termination by certified mail given by the party desiring to terminate to the other party. In the event that PMI shall desire to change Premiums or Benefits effective at the end of any Contract Term, advice of such changes will be given to County upon at least 30 days' written notice, and such notice shall renew the Contract for another Contract Term at the rates and with the coverage as stated in the notice unless County provides written notification to PMI by certified mail on or before the date stated in the notice that County does not choose to renew.

8.03 Acceptance by PMI of the proper Premiums after termination of this Contract and without requiring a new application, shall continue this Contract as though it had never terminated, unless PMI shall, within 20 business days of receipt of such payment, either i) refuse the payment so made, or ii) issue to County a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from this terminated Contract in Benefits, coverage or otherwise.

8.04 Non-Discrimination

a) No person shall be excluded from participation in, denied benefits of, or be subject to discrimination under this Agreement on the basis of their race, color, religion, national origin, age, sex, sexual orientation, pregnancy, childbirth or related conditions, medical condition, mental or physical disability or veteran's status. PMI shall ensure full compliance with federal, state and local laws, directives and executive orders regarding non-discrimination for all employees and Subcontractors under this Agreement. PMI shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

b) PMI Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject PMI to penalties, to be determined by the County Manager, including but not limited to: i) termination of this Agreement; ii) disqualification of PMI from bidding on or being awarded a County contract for a period of up to 3 years; iii) liquidated damages of $2,500 per violation; iv) imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this paragraph, the County Manager shall have the authority to: i) examine PMI's employment records with respect to compliance with this paragraph; ii) set off all or any portion of the amount described in this paragraph against amounts due to PMI under the Contract or any other Contract between PMI and County.

PMI shall report to the County Manager the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified PMI that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint and a description of the circumstance. PMI shall provide County with a copy of its response to the Complaint when filed.

8.05 Equal Benefits

With respect to the provision of employee benefits, PMI shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

ARTICLE 9. ATTACHMENTS

The following schedules are a part of this Contract:

Schedule A - Description of Benefits and Copayments

Schedule B - Limitations and Exclusions of Benefits

Schedule C - Group Variables and Premiums

Schedule D - COBRA Continuation Option

Schedule E - Performance Guarantees

Appendix A - Group Numbers

Appendix B - Equal Benefits Compliance Declaration Form

SCHEDULE A

DESCRIPTION OF BENEFITS AND COPAYMENTS

PLAN CAA16

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 USA program and are not to be interpreted as CDT-4 procedure codes, descriptors or nomenclature which are under copyright by the American Dental Association.

Code	Description	ENROLLEE PAYS
D0100-D0999	**I. Diagnostic**	
D0120	**Periodic oral** evaluation	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical, each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
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

Code	Description	ENROLLEE PAYS
D1000-D1999	**II. Preventive**	
D1110	**Prophylaxis *cleaning*** - adult - *1 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1201	Topical application of fluoride (including prophylaxis) - child - *to age 19; 1 per 6 month period*	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child - *to age 19; 1 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars 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.	
	* *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 USA program should be directed to PMI's Customer Relations department at (800) 422-4234.*	
	[1] *An amalgam is the benefit.*	
	[2] *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.*	
	[3] *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*	
	[4] *Replacement is subject to a limitation requiring the existing restoration to be 5+ 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 *[1]	Optional
D2392	Resin-based composite - two surfaces, posterior *[1]	Optional
D2393	Resin-based composite - three surfaces, posterior *[1]	Optional
D2394	Resin-based composite - four or more surfaces, posterior *[1]	Optional
D2510	Inlay - metallic - one surface [2,4]	No Cost
D2520	Inlay - metallic - two surfaces [2,4]	No Cost
D2530	Inlay - metallic - three or more surfaces [2,4]	No Cost

	Description	ENROLLEE PAYS
D2542	Onlay - metallic - two surfaces [2,4]	No Cost
D2543	Onlay - metallic - three surfaces [2,4]	No Cost
D2544	Onlay - metallic - four or more surfaces [2,4]	No Cost
D2610	Inlay - porcelain/ceramic - one surface *[4]	Optional
D2620	Inlay - porcelain/ceramic - two surfaces *[4]	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces *[4]	Optional
D2642	Onlay - porcelain/ceramic - two surfaces *[4]	Optional
D2643	Onlay - porcelain/ceramic - three surfaces *[4]	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces *[4]	Optional
D2650	Inlay - resin-based composite - one surface *[4]	Optional
D2651	Inlay - resin-based composite - two surfaces *[4]	Optional
D2652	Inlay - resin-based composite - three or more surfaces *[4]	Optional
D2662	Onlay - resin-based composite - two surfaces *[4]	Optional
D2663	Onlay - resin-based composite - three surfaces *[4]	Optional
D2664	Onlay - resin-based composite - four or more surfaces *[4]	Optional
D2710	Crown - resin (indirect) [3,4]	No Cost
D2720	Crown - resin with high noble metal [2,3,4]	No Cost
D2721	Crown - resin with predominantly base metal [3,4]	No Cost
D2722	Crown - resin with noble metal [3,4]	No Cost
D2740	Crown - porcelain/ceramic substrate [3,4]	No Cost
D2750	Crown - porcelain fused to high noble metal [2,3,4]	No Cost
D2751	Crown - porcelain fused to predominantly base metal [3,4]	No Cost
D2752	Crown - porcelain fused to noble metal [3,4]	No Cost
D2780	Crown - ¾ cast high noble metal [2,4]	No Cost
D2781	Crown - ¾ cast predominantly base metal [4]	No Cost
D2782	Crown - ¾ cast noble metal [4]	No Cost
D2790	Crown - full cast high noble metal [2,4]	No Cost
D2791	Crown - full cast predominantly base metal [4]	No Cost
D2792	Crown - full cast noble metal [4]	No Cost
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* [2]	No Cost
D2953	Each additional cast post - same tooth - *includes canal preparation* [2]	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

Code	Description	ENROLLEE PAYS
D3000-D3999	**IV. Endodontics**	
[5]	*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
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) [5]	No Cost
D3320	*Root canal* - bicuspid (excluding final restoration) [5]	No Cost
D3330	*Root canal* - molar (excluding final restoration) [5]	No Cost
D3346	Retreatment of previous root canal therapy - anterior [5]	No Cost
D3347	Retreatment of previous root canal therapy - bicuspid [5]	No Cost
D3348	Retreatment of previous root canal therapy - molar [5]	No Cost
D3410	Apicoectomy/periradicular surgery - anterior [5]	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) [5]	No Cost
D3425	Apicoectomy/periradicular surgery - molar (first root) [5]	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root) [5]	No Cost
D3430	**Retrograde filling - per root** [5]	**No Cost**
D3450	Root amputation, per root - *not covered in conjunction with procedure D3920* [5]	No Cost
D4000-D4999	**V. Periodontics**	
	Includes preoperative and postoperative evaluations and treatment under a local anesthetic.	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	No Cost
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	No Cost
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	No Cost
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant - *limited to 4 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	ENROLLEE PAYS

D5000-D5899 VI. Prosthodontics (removable)

[6] *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.*

[7] *Limited to 1 per denture during any 12 consecutive months.*

[8] *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

D5110	Complete denture - maxillary [6,8]	No Cost
D5120	Complete denture - mandibular [6,8]	No Cost
D5130	Immediate denture - maxillary [6,8]	No Cost
D5140	Immediate denture - mandibular [6,8]	No Cost
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [6,8]	No Cost
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [6,8]	No Cost
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [6,8]	No Cost
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [6,8]	No Cost
D5410	Adjust complete denture - maxillary [6]	No Cost
D5411	**Adjust complete denture - mandibular** [6]	**No Cost**
D5421	Adjust partial denture - maxillary [6]	No Cost
D5422	Adjust partial denture - mandibular [6]	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 [7]	No Cost
D5711	Rebase complete mandibular denture [7]	No Cost
D5720	**Rebase maxillary partial denture** [7]	**No Cost**
D5721	Rebase mandibular partial denture [7]	No Cost
D5730	Reline complete maxillary denture (chairside) [7]	No Cost
D5731	Reline complete mandibular denture (chairside) [7]	No Cost
D5740	Reline maxillary partial denture (chairside) [7]	No Cost
D5741	Reline mandibular partial denture (chairside) [7]	No Cost
D5750	Reline complete maxillary denture (laboratory) [7]	No Cost
D5751	Reline complete mandibular denture (laboratory) [7]	No Cost
D5760	Reline maxillary partial denture (laboratory) [7]	No Cost
D5761	Reline mandibular partial denture (laboratory) [7]	No Cost
D5820	**Interim partial denture (maxillary)** - *limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing* [6]	No Cost
D5821	Interim partial denture (mandibular) - *limited to initial placement of interim partial denture / stayplate to replace extracted anterior teeth during healing* [6]	No Cost
D5850	Tissue conditioning, maxillary [6,7]	No Cost
D5851	Tissue conditioning, mandibular [6,7]	No Cost

D5900-D5999 VII. Maxillofacial Prosthetics - Not Covered

D6000-D6199 VIII. Implant Services - Not Covered

Code	Description	ENROLLEE PAYS

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

* *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 USA program should be directed to PMI's Customer Relations department at (800) 422-4234.*

[2] *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.*

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

[9] *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

D6210	Pontic - cast high noble metal [2,9]	No Cost
D6211	Pontic - cast predominantly base metal [9]	No Cost
D6212	Pontic - cast noble metal [9]	No Cost
D6240	Pontic - porcelain fused to high noble metal [2,3,9]	No Cost
D6241	Pontic - porcelain fused to predominantly base metal [3,9]	No Cost
D6242	**Pontic - porcelain fused to noble metal [3,9]**	**No Cost**
D6245	Pontic - porcelain/ceramic * [9]	Optional
D6250	Pontic - resin with high noble metal [2,3,9]	No Cost
D6251	**Pontic - resin with predominantly base metal [3,9]**	**No Cost**
D6252	Pontic - resin with noble metal [3,9]	No Cost
D6600	Inlay - porcelain/ceramic, two surfaces * [9]	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces * [9]	Optional
D6602	Inlay - cast high noble metal, two surfaces [2,9]	No Cost
D6603	Inlay - cast high noble metal, three or more surfaces [2,9]	No Cost
D6604	Inlay - cast predominantly base metal, two surfaces [9]	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces [9]	No Cost
D6606	Inlay - cast noble metal, two surfaces [9]	No Cost
D6607	Inlay - cast noble metal, three or more surfaces [9]	No Cost
D6608	Onlay - porcelain/ceramic, two surfaces * [9]	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces * [9]	Optional
D6610	Onlay - cast high noble metal, two surfaces [2,9]	No Cost
D6611	Onlay - cast high noble metal, three or more surfaces [2,9]	No Cost
D6612	Onlay - cast predominantly base metal, two surfaces [9]	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces [9]	No Cost
D6614	Onlay - cast noble metal, two surfaces [9]	No Cost
D6615	Onlay - cast noble metal, three or more surfaces [9]	No Cost
D6720	Crown - resin with high noble metal [2,3,9]	No Cost
D6721	Crown - resin with predominantly base metal [3,9]	No Cost
D6722	Crown - resin with noble metal [3,9]	No Cost
D6740	Crown - porcelain/ceramic * [9]	Optional
D6750	Crown - porcelain fused to high noble metal [2,3,9]	No Cost
D6751	Crown - porcelain fused to predominantly base metal [3,9]	No Cost
D6752	Crown - porcelain fused to noble metal [3,9]	No Cost
D6780	Crown - ¾ cast high noble metal [2,9]	No Cost
D6781	Crown - ¾ cast predominantly base metal [9]	No Cost

	Description	ENROLLEE PAYS
D6782	Crown - ¾ cast noble metal [9]	No Cost
D6790	Crown - full cast high noble metal [2,9]	No Cost
D6791	Crown - full cast predominantly base metal [9]	No Cost
D6792	Crown - full cast noble metal [9]	No Cost
D6930	Recement fixed partial denture	No Cost
D6940	Stress breaker [9]	No Cost
D6970	Cast post and core in addition to fixed partial denture retainer - *includes canal preparation* [2]	No Cost
D6971	Cast post as part of fixed partial denture retainer - *includes canal preparation* [2]	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* [2]	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

Includes preoperative and postoperative evaluations and treatment under local anesthetic.

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

D8000-D8999 XI. Orthodontics

[10] *Listed Copayment covers up to 24 months of active orthodontic treatment excluding the services listed for D8999 "Start-up fee". Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

[11] *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.*

[12] *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [10]	$1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [10]	$1000.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including dependent adults covered as full-time students* [10]	$1000.00
D8660	Pre-orthodontic treatment visit - *not to be charged with any other consultation procedure(s)* [11]	No Cost

Code	Description	ENROLLEE PAYS
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) [12]	No Cost
D8999	Unspecified orthodontic procedure, by report -includes START UP FEES (including initial examination, diagnosis, consultation and initial banding)	$350.00
D9000-D9999	**XII. Adjunctive General Services**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
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
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 Relations department at (800) 422-4234.

SCHEDULE B

LIMITATIONS OF BENEFITS

1. Full mouth x-rays are limited to one set every 24 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 one procedure each six 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 five+ 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;

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 five+ or more years prior to its replacement, **or**
        - If an existing partial denture is less than five+ 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 four quadrants during any 12 month period;

17. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period;

18. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
    a. Fixed partial denture (bridge):
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved; **or**
        - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics (see Limitation #12); **or**
        - Each abutment tooth to be crowned meets Limitation #8;
    b. Removable partial denture
        - Cast metal (D5213, D5214), one or more teeth are missing in an arch;
        - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #12);

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.

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

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 USA 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 *Section 4.04*. To obtain written authorization, the Enrollee should call PMI's Customer Relations department at (800) 422-4234;

11. Consultations for non-covered benefits;

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age;

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;

15. 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);

16. 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 USA 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;

17. 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;

18. 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;

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

ORTHODONTIC LIMITATIONS

The DeltaCare USA 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 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 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 two years;

3. Treatment plans extending beyond 24 months of active treatment, or 24 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 $2,800.00 for covered dependent children to age 19 and $3,000.00 for covered adults and dependent children to age 30. The amount will be 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;

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 and customary fee;

   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. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models;

2. Lost, stolen or broken orthodontic appliances;

3. Retreatment of orthodontic cases;

4. Changes in treatment necessitated by accident of any kind;

5. Initial or continuing orthodontic treatment when such treatment would be inconsistent with generally accepted professional standards;

6. Surgical procedures incidental to orthodontic treatment;

   Myofunctional therapy;

8. Surgical procedures related to cleft palate, micrognathia, or macrognathia;

9. Treatment related to temporomandibular joint disturbances;

10. Supplemental appliances not routinely used in typical comprehensive orthodontics;

11. Restorative work caused by orthodontic treatment;

12. Phase I orthodontics[13], 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. Composite bands, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

[13] *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), up to a Maximum of $1,600.00 in any 12 month period.

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*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #15, #20, #21 and #24 and exclusions #1-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis;
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue);
3. Replacement of existing restorations due to decay;
4. Orthodontic services (treatment of malalignment of teeth and/or jaws);
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

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

SCHEDULE C

GROUP VARIABLES AND PREMIUMS

A. Group Name: County of San Mateo

B. Group Number: (See Appendix A)

C. Effective Date: October 1, 2006

D. Contract Term: 36 Months

E. Eligible Present Employees: As defined by County.

Eligible New Employees: As defined by County.

F. Premiums per Month:

Plan Type: CAA16

California Composite $40.66

G. Remit Premium Payment to: PMI
Dept. #0170
Los Angeles, California 90084-0170

SCHEDULE D

OPTIONAL CONTINUATION OF COVERAGE (COBRA OR CAL-COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to employers with 2 to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." An employee or dependent may be entitled to continue coverage under this program, *at the Qualified Beneficiary's expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section are shown below.

Qualified Beneficiary means a person enrolled in the DeltaCare USA plan on the day before the Qualifying Event, including:

1. an employee and his or her dependents, or;

2. a child who is born to or placed for adoption with the employee during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event mean any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1: The termination of employment (other than termination for gross misconduct), or the reduction in work hours, by the employer;

Event 2: the employee's death;

Event 3: the employee's divorce or legal separation from his or her spouse;

Event 4: Dependents' loss of dependent status under the plan; and

Event 5: As to dependents only, the employee's entitlement to Medicare.

PERIODS OF CONTINUED COVERAGE

An employee or dependent may continue coverage for 18 months following the occurrence of Qualifying Event 1.

This 18 month period can be extended for a total of 29 months, provided:

a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continued coverage; and

2. notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The employee must notify the employer/administrator within 30 days of any such determination.

If, during the 18 month continuation period resulting from Qualifying Event 1, dependents experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Enrolled dependents may continue coverage for 36 months following the occurrence of Qualifying Event 2, 3, 4 or 5.

Under federal COBRA law only, when an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the employee is the retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the employee's death.

ELECTION OF CONTINUED COVERAGE

The employee's former employer shall notify PMI in writing within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify the Administrator in writing within 60 days of Qualifying Events 2, 3, 4, or 5. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, PMI will provide a Qualified Beneficiary with the necessary benefits information, monthly premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give PMI written notice of the election to continue coverage. Failure to provide this written notice of election to PMI within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to PMI, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continued coverage, and any premiums received after that date will be returned to the Qualified Beneficiary.

A Qualified Beneficiary who is eligible for coverage under the federal COBRA law may not be covered under Cal-COBRA.

CONTINUED COVERAGE BENEFITS

The benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occurs:

1. the allowable number of consecutive months of continued coverage is reached;

2. the individual fails to pay the required premium in a timely manner;

3. the individual first obtains coverage for dental benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such person, if that pre-existing condition is covered under this program;

4. the employer ceases to provide any group dental plan to its employees;

5. the individual becomes entitled to Medicare;

6. the individual moves out of the plan's service area;

7. the individual becomes eligible for coverage under the federal COBRA law.

The employer shall notify PMI within 30 days of the date when a Qualified Beneficiary becomes so eligible.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and PMI terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary under Cal-COBRA (either 30 days prior to the termination or when all Enrollees are notified whichever is later) of that person's ability to elect continuation coverage under the employer's subsequent dental plan, if any. The employer must notify the successor plan of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage under that plan.

The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare USA program had such program with the former employer not terminated. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premium to the new group benefit plan within 30 days of receiving notice of the termination of the DeltaCare USA program.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary under Cal-COBRA may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare USA program.

SCHEDULE E

DELTACARE
PERFORMANCE GUARANTEES

PMI will place 10% of DeltaCare USA administration fee* at risk. While performance is monitored monthly, penalties, if any, will be based on annual performance results and paid annually.

PMI is committed to the highest level of service and is dedicated to consistently meeting or exceeding County of San Mateo expectations in the following areas:

Performance Requirement	Expected Standards/Results	% of Admin. Fee at Risk
Account Management	An Account Executive and Account Manager will be assigned as contacts for County of San Mateo to:	Total 1.5%
	a) Successfully oversee all implementation activities, including participation in informational meetings for employees;	.50%
	b) Schedule meetings with County of San Mateo to ensure smooth service of the account and on an as needed basis to discuss and resolve open issues; and	.50%
	c) Return phone calls and e-mails from County of San Mateo primary contacts within one business day.	.50%
	County of San Mateo will monitor and evaluate PMI's account management performance on an ongoing basis, and will report to PMI at any time the County of San Mateo determines these Performance Guarantees are not being met.	
Customer Service Responsiveness	Over the course of a contract year:	Total 1.5%
	a) 85 percent of all customer calls to the Customer Service department will be answered within 30 seconds; and	.75%
	b) Call abandonment rate will be less than 5 percent.	.75%
	Performance will be measured globally and reported annually.	
Customer Satisfaction	Overall customer satisfaction is measured by a survey distributed to a random sampling of PMI enrollees. 85 percent of satisfaction survey participants will be satisfied or very satisfied. Measurement will be reported annually based on the results of the last 12-month period.	Total 1.5%
Quality Management	a) A written response will be provided that acknowledges receipt of the grievance within five business days for 95% of enrollees filing a grievance.	Total 1.5%
	b) 95% of all quality of care grievances will be resolved within 30 days after opening grievance.	.375%
	c) All new contract dentists will be credentialed upon application and will be recredentialed, at a minimum, once every 3 years.	.75%
	Performance will be measured globally and reported annually.	.375%

Performance Requirement	Expected Standards/Results	% of Admin. Fee at Risk
Network Access	85 percent of all facilities open to new enrollees shall have appointment access for non-specific time requests not to exceed four weeks for routine/initial visits and six weeks for hygiene appointments. Performance will be measured globally and reported annually, based on current panel status.	Total 1%
Network Stability	a) Annual turnover of contract dentists will be less than 10 percent. Performance will be measured globally and reported annually. b) Overall provider satisfaction is measured by a survey distributed to a random sampling of PMI providers. 85 percent of provider satisfaction participants will be satisfied or very satisfied. Measurement will be reported annually based on the results of the last 12-month period.	Total 1% .50% .50%
Claims Processing	Over the course of a contract year: a) 85 percent of all specialty care preauthorizations will be processed within 10 business days; and b) 85 percent of all clean specialty care and out-of-area emergency claims will be processed within 15 business days after receiving complete information. Performance will be measured globally and reported annually.	Total .75% .375% .375%
Eligibility Administration	a) 95 percent of group submitted eligibility will be processed within three business days; b) 98 percent of ID cards will be issued within 10 business days after receipt of accurate eligibility data. Performance will be measured on a group-specific basis and reported annually.	Total .75% .375% .375%
Group Reports	PMI will provide annual group-specific financial and service utilization reports within 60 business days from the close of the contract period.	Total .5%

* Administration fee, excluding premium tax and commission.

PMI shall not be liable to County of San Mateo or be deemed to be in breach of these Performance Guarantees for any failure or delay in performance arising out of causes beyond its reasonable control and without its fault or negligence. Such causes are strictly limited to include acts of God or a public enemy, explosion, fires or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided PMI notifies County of San Mateo promptly of the existence and nature of the delay.

APPENDIX A

Group #	Group Name
01444-0001	County of San Mateo
01444-0002	County of San Mateo - COBRA
01444-0003	County of San Mateo - Retirees