County of Santa Cruz

PERSONNEL DEPARTMENT
701 OCEAN STREET, SUITE 310, SANTA CRUZ, CA 950604073
(831) 454-2600 FAX: (831) 454-2411 TDD: (831) 454-2123
DANIA TORRES WONG, DIRECTOR

August 30, 1999

Agenda Date: September 21, 1999

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

CONTRACT RENEWAL FOR DELTA/CARE PMI

Dear Members of the Board:

The dental insurance contract for DeltaCare/Private Medical Care (PMI) will expire October 1, 1999.

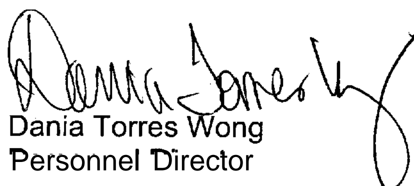
PMI is one of two plans providing dental coverage to County employees. For the 1999/2000 contract year, PMI has requested their first premium increase since October 1996. PMI has requested and we are recommending a 3.5% rate increase from $18.52 per pay period to $19.17 from October 2, 1999, through September 29, 2000. The rate increase is required to maintain the current benefit structure and fund capitation and speciality care trends.

In addition to the rate increase, an Amendment to the contract is included for your approval. The specific changes addressed in this Amendment are needed to meet state and federal requirements.

The employee dental benefits provided through this contract are required in agreements with employee organizations. Premiums for this benefit are budgeted in the individual department budgets.

It is therefore RECOMMENDED that your Board authorize the Personnel Director to sign an amendment with Private Medical Care, Inc. (PMI) increasing the biweekly premium from $18.52 to $19.17 per pay period through September 29, 2000 and modify the existing contract to incorporate various changes required by state and federal law.

Very truly yours,



Dania Torres Wong
Personnel Director

RECOMMENDED:

SUSAN A. MAURIELLO
County Administrative Officer

DTW: JW:jw

CC: Personnel

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

AMENDMENT TO GROUP DENTAL SERVICE CONTRACT (Prepaid)

As of the date stated below,, the Group Dental Service Contract ("Contract") issued to you by Private Medical-Care, Inc. (PMI) is amended as follows to comply with changes in state and federal law which apply to this Contract.

1. The following Definitions are added to the list of Definitions in Article 1. DEFINITIONS:

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

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

2. Article 4. BENEFITS, LIMITATIONS AND EXCLUSIONS is modified as follows:

   A. The following sentence is added to Section 4.03:

      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.

   B. Section 4.04 is replaced by the following:

      4.04 If an Enrollee is more than thirty-five (35) miles from the office of the assigned Panel 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 ninety (90) days after such treatment is received.

      If an Enrollee has been enrolled less than thirty (30) days, and if the Enrollee is currently experiencing an Acute Condition, he or she should contact PMI's Customer Relations Department at 1-800-422-4234 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 Panel 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; and

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

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; and

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

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

PMI may require a non-Panel 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-Panel Dentist.

C. The following provision is added as Section 4.10:

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

D. The following provision is added as Section 4.11:

4.11 PMI does not authorize or deny services provided by a Panel Dentist. All Benefits provided by a Panel Dentist are in accordance with Dental Care Guidelines which establish the standard of care to be followed by Panel Dentists. PMI's "processing policies" and the 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 1-800-422-4234 for information regarding PMI's "processing policies".

E. The following provision is added as Section 4.12:

4.12 PMI may request that an Enrollee obtain a second opinion to verify the necessity and appropriateness of dental treatment or application of Benefits. When PMI requests a second opinion, it will pay for all second opinion charges. An Enrollee may also request a second opinion if he or she disagrees with the diagnosis and/or treatment plan determination made by his or her Panel Dentist. In such cases, the Enrollee should contact PMI's

Customer Relations Department for assistance in requesting authorization for a second opinion. Second opinions will only be authorized at a Panel Dentist's office, unless otherwise authorized by PMI's Dental Consultant. Charges for second opinions that are not authorized by PMI are excluded from coverage.

3. Article 5. COORDINATION OF BENEFITS is modified as follows:

   A. Section 5.01 is replaced by the following:

      5.01 This Contract provides Benefits without regard to coverage by any other group insurance policy or any other group benefits program if the other policy or program covers services in addition to dental care. Otherwise, Benefits under this Contract are coordinated with such other group insurance or any group health benefits program.

   B. The first paragraph of Section 5.02 is replaced by the following:

      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:

4. Article 6. COMPLAINT PROCEDURE, CLAIMS APPEAL AND ARBITRATION is modified as follows:

   A. All references to PMI's Quality Assurance Coordinator, are changed to PMI's Quality Management Coordinator.

   B. The following provisions are added. If your Contract already includes provisions concerning this matter, the following provisions replace the provisions already in your Contract.

   Within 30 days after PMI receives an Enrollee's written complaint and the above information, PMI will send the Enrollee a report which describes the complaint and PMI's resolution, or explains why additional time is required to report on the complaint. In the event the Enrollee disagrees with the resolution of the complaint, he or she may submit a written request for reconsideration within 15 days after he or she receives that response. The Enrollee should provide the reason for the appeal and any additional information which he or she feels may affect his or her case. PMI may require additional documents as it deems necessary or desirable in making a review. Within 30 days after PMI receives the appeal and supporting documentation, PMI will forward to the Enrollee a written response or an explanation of why additional time is required.

   If an Enrollee is dissatisfied with PMI's response and he or she has been involved in PMI's grievance and appeals process for 60 days, the Enrollee may contact the Department of Corporations for assistance. The Enrollee may file a complaint with the Department immediately in an emergency situation, which is one involving imminent and serious danger to his or her health.

   The California Department of Corporations is responsible for regulating health

service plans. The Department has a toll-free telephone number **(1 - 800- 400- 0815)** to receive complaints against health plans. If an Enrollee has a grievance against the health plan, he or she should contact the plan and use the plan's grievance procedure. If the Enrollee needs the Department's help with a complaint involving an emergency procedure or with a grievance that has not been satisfactorily resolved by the plan, he or she may call the Department's toll-free telephone number.

C. The following paragraph is added, and shall be the last paragraph in this Article:

In the event of extreme hardship on the part of an enrollee and upon an application for relief presented to the American Arbitration Association ("AAA"), PMI shall assume all or a portion of the arbitration fees and expenses as determined by the AAA in accordance with procedures established and administered by the AAA.

5. The third paragraph of the COBRA CONTINUATION OPTION in SCHEDULE E is replaced by the following two paragraphs:

A Primary Enrollee who is entitled to continue coverage as a result of Qualifying Event (a) or (b) above may continue that coverage, for himself or herself and any Dependent Enrollees, for 29 months if the Primary Enrollee is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time the Qualifying Event occurred or to have become so disabled within 60 days after such event occurred. The Primary Enrollee must notify the Applicant during the initial 18 months and within 60 days after the date of determination, and extended coverage for disability will terminate on the first day of the month that begins more than 30 days after the date of final determination that the Primary Enrollee is no longer disabled.

A Dependent Enrollee who has elected to continue coverage because (i) Qualifying Event (a) or (b) occurred to the Primary Enrollee, and (ii) the Primary Enrollee did not elect continued coverage for that Dependent Enrollee, and who is or becomes disabled within 60 days after that event, may also continue coverage, for himself or herself and any other Dependent Enrollees, for 29 months, subject to the notice and termination requirements described above with respect to the Primary Enrollee.

IN WITNESS WHEREOF, PRIVATE MEDICAL-CARE, INC. has executed this Amendment on the 19th day of March , 1999.

By: [signature]
Marilyn T. Masters
Vice President, Underwriting

[APPROV]ED AS TO FORM:
By: [signature] 9/13/99
Office of the County Counsel

APPENDIX A

Group #	Group Name
0368	County of Santa Cruz
1919	County of Santa Cruz/COBRA

Group #0368 (Biweekly)

Composite	$19.17	effective 10/1/1999

Group #1919 (COBRA - Monthly)

Composite	$41.54	effective 10/1/1999