

Pacesetter/Mission/Harbor Plans

Summary of Benefits and Disclosure Form



Welcome to a Plan with Values!

Golden West Dental & Vision is a statewide health care service plan. We are dedicated to providing excellent service and quality dental programs to individuals and employees throughout the State of California. Our staff includes experienced health care professionals in Member Services, Provider Relations, Claims, and Administration.

An Ounce of Prevention...

Our objective is for you and your family to achieve a good level of dental health and maintain this level without high premiums. Because preventive and diagnostic services are provided at little or no cost, you are encouraged to maintain excellent oral health. If you should require other services, significant discounts are given by our quality network of dentists.

Quality Private Practice Dental Offices...

As a member enrolled in the Golden West dental program, your dental care is available through a network of private practice dentists and specialists throughout the State of California. Each provider office must pass a thorough quality assurance review performed by one of Golden West's staff dentists. Periodic evaluations assure that each dental office maintains prescribed standards.

Who Can Join?

California employees and their eligible dependents. Eligible dependents include your lawful spouse and unmarried children to the age of 19 (age 23 if full-time student), and children who are dependent upon you for support due to mental or physical disability regardless of age. Note: Some group benefit contracts contain different eligibility provisions.

This Disclosure Booklet is only a summary of the most important features of the Dental Plan. The Contract and Evidence of Coverage must be consulted to determine the exact terms, limitations, and exclusions of coverage. The enrollee has a right to review a specimen copy of the contract prior to enrollment. A specimen copy of the contract is available at the administrative offices of Golden West Dental & Vision.

A statement describing Golden West Dental & Vision's policies and procedures for preserving the confidentiality of medical records is also available upon request from Golden West's administrative offices.

This Disclosure Booklet and all inserts and the Contract and Evidence of Coverage should be read completely and carefully so you will understand how the plan works and how benefits may be obtained. If you have any questions or need assistance, please contact Golden West Dental & Vision at (800) 995-4124.

How to enroll and select a provider...

You may enroll by completing an enrollment form and submitting it to your Human Resources Department for processing. Be sure to fill in all information on the form including the names of all dependents you wish to enroll. You may select a network general dentist at the time of enrollment, or when you first need services under the Plan. If you wait until the point of service, you will automatically be enrolled in the dentist's office upon receipt of the first claim. You and your eligible dependents may each select your own dentist up to a maximum of three dentists per family. A current list of network providers is included with your enrollment material.

Commencement of Benefits...

Benefits will become effective on the first of the month following receipt of the completed enrollment form in the Golden West administrative offices. Your Human Resources Manager can advise you of your group's benefit eligibility period and the date your benefits will begin.

How does my Plan work?

If you access dental care from a Golden West network general dentist, you will be responsible only for the copayments for services listed on the Plan's fee schedule included with your enrollment material. There are no annual maximums or deductibles. You will enjoy significant savings by receiving covered services from a network general dentist.

What if my dentist isn't in the network?

You may be able to access dental treatment from a Non-Panel Provider if your Plan includes an Out-of-Network Benefit. If your plan includes an Out-of-Network benefit, an annual maximum will apply to all services received from a Non-Panel Provider. Please refer to the enclosed Benefit Summary for more information on your group's specific plan design.

Making an appointment...

Simply phone your selected dental office when you wish to make an appointment. Your appointment time will depend upon the service the dental office has determined necessary for you, their availability, and yours. Certain popular appointment times are more difficult to obtain than others. We recommend that you schedule appointments well in advance and that you be as flexible as possible in your choice of times. Please remember, time is valuable both to you and your dental office. If you cannot keep your scheduled appointment, notify your dental office at least 24 hours prior to your scheduled time.

What if I need a specialist?

Most often, your Plan benefits can be performed by your general dentist. However, in some instances, your general dentist may feel that referral to a specialist is necessary. Please refer to the Summary of Benefits included with this enrollment material for specialty referral guidelines applicable to your specific Plan.

Does treatment need to be preauthorized?

Treatment at the general dentist's office does not require preauthorization; however, we recommend that you ask your provider to preauthorize all treatment plans over \$300. As an informed

consumer, you want to know how much your dental treatment will cost prior to services being rendered.

What if I have a dental emergency?

A dental emergency is defined as the sudden onset of oral pain, swelling, or bleeding, or oral infection that requires immediate professional treatment. If you require emergency dental treatment, you should call your general dentist. If you are unable to reach your general dentist, you may telephone Golden West 24 hours a day at (800) 995-4124. A Member Services Representative will assist you in obtaining dental emergency treatment.

Coordination of Benefits...

The purpose of this Plan is to help a person pay for his/her dental care expenses. If coverage is provided under any other plan, benefits available under this Plan and the other plan might exceed actual expenses incurred. If this is the case, the combined benefits payable under this Plan and the other plan will not exceed the total amount charged.

Alternate Benefit Provision...

All diagnosis and treatment planning is provided by your selected dental office. Occasionally, you and your dentist may consider possible alternative treatment plans. In those instances where you select an enhanced treatment plan as opposed to the benefit allowed by Golden West, you will be responsible to pay the difference between the usual fee for the enhanced treatment and the covered benefit, plus the copayment for the covered benefit. Providers are expected to discuss enhanced benefits with you before you agree to have any services performed. The cost of these benefits should be confirmed in writing by the provider. You should ask your provider to preauthorize any treatment plans exceeding \$300.

Continuity of care...

In the event of termination of this Plan or the agreement with the network general dentist, the network general dentist shall complete any definitive procedure started prior to the termination under the terms of this program, with the exception of any orthodontic treatment. If you need assistance, you may telephone Golden West at (800) 995-4124.

Resolution of disputes

If you are dissatisfied with the services rendered by your network general dentist or with Golden West Dental & Vision, please call our Member Services Department at (800) 995-4124 or submit your concerns in writing. A Member Resolution Form for this purpose will be mailed to you at your request. Resolution of your concern will be made within 30 days, or you will receive notification that additional information/time is needed in order for resolution to be made. You may write to us at:

GOLDEN WEST DENTAL & VISION

PO Box 5347

Oxnard, CA 93031-5347

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The DMHC has a toll-free telephone number (1-888-HMO-2219) to receive complaints

regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the DMHC. The DMHC's Internet website (www.hmohelp.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your Plan at 1-800-995-4124 and use the Plan's grievance process before contacting the DMHC. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the DMHC for assistance. The Plan's grievance process and the DMHC's complaint review process are in addition to any other dispute resolution procedure that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Binding Arbitration...

You are required to submit all complaints regarding your Plan through Golden West Dental & Vision's internal resolution procedures before filing for arbitration for final and binding resolution of the complaint. Arbitration is the final process for resolution of any dispute. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Either party to a dispute may initiate arbitration by written notice to the other party to the dispute by filing two copies of such notice with the American Arbitration Association together with the fee required by the Association. In the event of extreme hardship, you may file an application for relief with the American Arbitration Association, and Golden West will assume all or a portion of your share of the arbitration fees and expenses as determined by the American Arbitration Association under its procedures.

Termination of Coverage/Renewal...

Your group dental plan will automatically renew on the anniversary of the contract term unless your employer group notifies Golden West Dental & Vision that the group dental plan should be terminated, or in the event premiums are not paid. Any notice of termination must be given in writing thirty (30) days in advance of the effective date of group termination.

Continuation of Coverage...

In accordance with Federal legislation (i.e. COBRA), or state legislation (i.e. CAL-COBRA), you or your family members may have certain rights to continue group coverage if your eligibility is terminated due to specific qualifying events. A monthly premium may be charged to you for the continuation of coverage. If you have any questions about continuation of coverage, please contact your Human Resources Manager.

Definitions

ADA - American Dental Association.

ALLOWABLE CHARGES - Will be the charges of the dentist up to such limits as may objectively be determined by Golden West Dental & Vision.

COPAYMENT - Additional fees required for specific services. These fees are paid by the member directly to the Network Dentist.

DENTAL EMERGENCY - The sudden onset of oral pain, swelling, or bleeding, or oral infection that requires immediate professional treatment.

GROUP - Organization or employing unit with which subscriber is associated.

MEMBER - Any individual subscriber or eligible family dependent entitled to receive services under this dental plan.

NETWORK DENTIST - A licensed professional who provides services for the member and with whom Golden West Dental & Vision has contracted.

NON-PANEL PROVIDER - A licensed professional not under contract with Golden West Dental & Vision.

SPECIALIST - Specialist is defined as oral surgeons, endodontists, periodontists, and pedodontists. All other specialties are excluded.

SUBSCRIBER - Individual in whose name family unit is enrolled.

TREATMENT IN PROGRESS - Any treatment, as identified by a specific ADA code, which has been started but not completed.

Limitations

A. DIAGNOSTIC/PREVENTIVE

1. Examinations are limited to once in any six (6) consecutive month period.
2. Bitewing x-rays are limited to four (4) films in any six (6) consecutive month period.
3. Intraoral complete series (including bitewings), or Panorex, are limited to once every two (2) years for those insureds age 12 and over.
4. Other intraoral x-rays will be covered to a maximum of one (1) 220 single x-ray and four (4) 230 additional x-rays every twelve (12) consecutive months.
5. Prophylaxis is limited to once in any six (6) consecutive month period. Either one prophylaxis or one perio maintenance procedure is allowed in any six (6) consecutive month period. Fluoride treatments may be provided in conjunction with prophylaxis for dependent children up to age 18. Prophylaxis is not payable if performed on same day as perio scaling.
6. Sealants are limited to one application on permanent first and second molars up to age 16.
7. Allowance for fixed space maintainers includes initial appliance only and all adjustments in first six (6) months for dependent children up to age 16.

B. RESTORATIVE

1. Soft tissue preparation, temporary restorations, cement bases, impressions and local anesthesia are considered components of the fee for the completed restoration.
2. Replacement fillings will be considered after twenty-four (24) months from initial placement.
3. Benefits for composite resin restorations on posterior teeth and anterior primary teeth are based on the corresponding amalgam benefit. See Alternate Benefit Provision.
4. Benefits for the treatment of rampant caries are limited to the first seven (7) most severely decayed primary teeth, subject to all plan limitations. Rampant caries is defined as eight (8) or more decayed primary teeth.

C. CROWNS

1. Cast restorations and crowns are covered only when extensive coronal destruction is radiographically evident and tooth cannot be restored with an intracoronal restoration, unless tooth is diagnosed as having cracked tooth syndrome.
2. Crowns on deciduous teeth are limited to stainless steel.

3. Benefits for noble and high noble metal are based on the corresponding porcelain or base metal crown. See Alternate Benefit Provision.
- D. ENDODONTICS
 1. Therapeutic pulpotomy is payable only if performed on deciduous teeth when decay is near nerve of tooth.
 2. Direct/indirect pulp capping is payable only if performed on permanent teeth when decay is near nerve of tooth, and only if no other endodontic procedure is performed.
- E. PERIODONTICS
 1. Gingivectomy is limited to four (4) quadrants in any thirty-six (36) consecutive month period.
 2. Gingival curettage and periodontal scaling and root planing is limited to four (4) quadrants in any twenty-four (24) consecutive month period. No more than two (2) quadrants may be performed on same day.
 3. Osseous surgery is limited to four (4) quadrants per lifetime.
 4. Full mouth debridement is limited to once in any twenty-four (24) consecutive month period. Full mouth debridement will not be payable if performed on same day as periodontal scaling and root planing.
 5. One periodontal maintenance procedure is allowed every six (6) consecutive months in lieu of prophylaxis. Periodontal maintenance procedures are allowed only after completion of surgical or non-surgical periodontal treatment, excluding full mouth debridement.
- F. PROSTHODONTICS
 1. Allowance for prosthodontics includes base, clasps, rests, and teeth, and all adjustments in first six (6) months after initial placement of denture.
 2. Denture adjustments are covered only after six (6) months from time of initial denture placement.
 3. Denture repairs are covered only after twelve (12) months from time of initial denture placement.
 4. Denture relines are allowed once per denture in any twenty-four (24) consecutive month period after twelve (12) months from time of initial denture placement.
 5. Tissue conditioning is limited to two (2) treatments per arch in any twelve (12) consecutive month period.
 6. Fixed Bridgework: A fixed bridge in any posterior quadrant, when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic, is considered elective. An alternate benefit for a partial denture would be allowed. See Alternate Benefit Provision.
 7. Coverage for bridgework is limited to insureds age 16 and over.
- G. ORAL SURGERY
 1. Allowance for oral surgery includes routine x-rays, treatment plan, local anesthesia, and post-surgical care.
- H. OTHER
 1. Chairside labial veneers are limited to anterior permanent teeth.
5. Conditions resulting from disease or epidemic or injuries sustained as a result of a major disaster or war (declared or undeclared).
6. Dental procedures initiated prior to Member's eligibility under this benefit plan or started after Member's termination from the Plan.
7. Services performed for cosmetic, elective, or aesthetic purposes.
8. Services or supplies that do not meet accepted standards of dental practice, which are experimental in nature or are considered enhancements to standard dental care.
9. Implants and services incurred as part of implants, and fixed or removable prosthetics placed on implants.
10. Treatment related to temporomandibular joint syndrome (TMJ).
11. Appliances, restorations, or procedures to:
 - alter vertical dimension,
 - restore or maintain occlusion,
 - splint or stabilize teeth for periodontic reasons,
 - replace tooth structure lost as a result of abrasion, erosion, or attrition, or
 - treat bruxism (nightguards, harmful habit and thumbsucking devices).
12. Treatment and/or services (including biopsy) for malignancies, cysts, neoplasms, or congenital or developmental malformations, including but not limited to, cleft palate, enamel hypoplasia, fluorosis, anodontia, supernumerary or impacted teeth other than third molars.
13. General anesthesia, analgesia (including nitrous oxide), sedation, and prescription drugs.
14. Any inpatient/outpatient hospital or surgicenter charges of any kind including physician charges, prescriptions or medication.
15. Treatment for crown exposure, ligation, and crown lengthening.
16. Expenses incurred for initial placement or replacement of any appliance or fixed or removable prosthetic, unless such placement is necessitated by the extraction of one or more natural teeth while covered under this program. Any such appliance or fixed or removable prosthetic includes the replacement of the extracted tooth or teeth.
17. Replacement of an appliance or fixed or removable prosthetic with a like appliance or prosthetic unless the appliance or prosthetic is at least 5 years old and cannot be made usable. Replacement of crowns unless existing crown is more than five (5) years old.
18. Replacement of a lost, stolen, or missing appliance or prosthetic device.
19. An appliance or fixed or removable prosthetic device used to replace second and third molars.
20. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction (more than five units of crown and/or bridgework in one arch or more than nine units total). Extensive oral rehabilitation or reconstruction is available at the doctor's regular fee.
21. Resectioning of the bone and surgeries involving repositioning of the teeth or tooth implantation, re-implantation or transplantation. Also excluded are surgeries dealing with the salivary gland or sinus.
22. Oral surgery for fractures or dislocations of the jaw, resectioning of the bone, repositioning of the teeth or bone implantation or transplantation, salivary gland, duct or sinus. Orthognathic surgery and extractions for orthodontic purposes.
23. Elective oral surgery, including the extraction of non-pathologic, asymptomatic teeth, overretained deciduous teeth, and deciduous teeth which appear to be at or near exfoliation.
24. Orthodontic treatment unless specifically included. Under any applicable orthodontic benefits, treatment plans started before Member enrolled with the Plan are not covered.

Exclusions

The following treatment or services are not covered:

1. Any procedure not specifically listed as a covered service.
2. Any dental treatment which, in the opinion of the attending dentist, is not necessary for the patient's dental health, will not produce a beneficial result, or has a poor prognosis.
3. Services for injuries or conditions for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, medical health insurance, Worker's Compensation or Employer's Liability Laws.
4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political subdivision.