



# PLANS GE400 AND GE600

## DISCLOSURE & ENROLLMENT FORM

### DESCRIPTION OF BENEFITS CO-PAYMENTS

#### Area 2-Central/Northern California County list of participating dentists

Area 2-Central/Northern includes participating dentists in the following counties only - Alameda, Contra Costa, El Dorado, Fresno, Kern, Madera, Marin, Merced, Monterey, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, Yuba.

For services needed by a Plan Dentist outside your local area, different co-payments may apply.

This disclosure is only a summary of the Evidence of Coverage-Contract of Benefits. The Evidence of Coverage-Contract of Benefits must be consulted to determine the exact terms and conditions of coverage. You have a right to view the Evidence of Coverage-Contract of Benefits prior to enrollment. A copy of the Evidence of Coverage-Contract of Benefits is available upon request from SmileSaver Dental Plan's administrative office. This disclosure should be read completely and carefully. Individuals with special health care needs should read carefully those sections that apply to them. For additional information about your benefits, please call (800) 333-9561.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Welcome to SmileSaver Dental Plan! Principal Benefits and Coverage, Principal Exclusions and Limitations on Benefits and Other Charges are contained in the following Matrix.

### PLANS GE400 AND GE600 Area 2-Central/Northern

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE-CONTRACT OF BENEFITS SHOULD BE CONSULTED FOR DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

THIS IS A REVISED MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE DISCLOSURE FORM. REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

### PROFESSIONAL SERVICES

Co-payments listed are for services performed by your assigned participating general dentist.

**PREVENTIVE:** Comprehensive and Periodic oral exam, Oral hygiene instruction, X-rays, Sealants.

	Plan GE400	Plan GE600
	<b>Area-2 Central/Northern</b>	
Deductibles	None	None
Lifetime Maximums	None	None
Comprehensive oral exam	\$5	\$4
Periodic oral exam	\$5	\$4
Pulp vitality testing	No charge	No charge
Oral hygienic instruction	No charge	No charge
Full mouth x-rays	\$6	\$20
Sealants (per tooth)	\$10	\$16

**PROPHYLAXIS:** Prophylaxis, (routine cleaning)

	Plan GE400	Plan GE600
Deductibles	None	None
Lifetime Maximums	None	None
Prophylaxis (routine cleaning without fluoride treatment)(child)	\$10	\$27
Fluoride Treatment (child)	\$15	\$37

**Limitations:** Benefits for prophylaxis procedures are limited to once every six (6) months.

**RESTORATIVE:** Fillings (Amalgam and Resin Restorations), Crowns, Post and Core, Bridges.

	<u>Plan GE400</u>	<u>Plan GE600</u>
	<u>Area-2 Central/Northern</u>	
Deductibles	None	None
Lifetime Maximums	None	None
Fillings (Amalgam and Resin Restorations) (Children's teeth):		
Fillings (1 surface)	\$8	\$41
Fillings (2 surfaces)	\$15	\$52
Fillings (3 surfaces)	\$17	\$63
Fillings (4 or more surfaces)	\$24	\$76
Amalgam restorations (Adult teeth):		
Fillings (1 surface)	\$11	\$46
Fillings (2 surfaces)	\$17	\$59
Fillings (3 surfaces)	\$27	\$71
Fillings (4 or more surfaces)	\$30	\$87
Resin restorations (anterior/front teeth):		
Resin (1 surface)	\$24	\$57
Resin (2 surfaces)	\$30	\$72
Resin (3 surfaces)	\$36	\$89
Resin (4 or more surfaces)	\$42	\$111
Other restorative procedures:		
Sedative filling	No charge	\$41
Core build-up (including pins)	No charge	\$107
Pin retention (per tooth)	No charge	\$25
Crowns and Bridges including Pontics:		
Porcelain with metal (anterior tooth)	\$250*	\$480
Porcelain with metal (posterior tooth) (if crown medically necessary)	\$395*	\$420
Full cast base metal	\$175*	\$400
3/4 cast base metal	\$180*	\$410
Stainless steel (Child)	\$48	\$107
Stainless steel (Adult)	\$48	\$122
Cast endo post and core (in addition to crown)	\$50	\$166
Prefabricated endo post & core (in addition to crown)	\$30	\$129
Core build-up for retainer (including pins)	No charge	\$107
Recementation:		
Inlay	\$14	\$39
Crown	\$14	\$38
Recement Fixed Bridge work	\$20	\$58

**\*Subject to a six (6) month waiting period**

**Limitations:** Use of alloys with 25% or more noble (precious) metal content for any restorative procedure are considered optional and, if used, charges for such alloys are the Member's responsibility.

**ENDODONTIC:** Pulp cap, Pulpotomy, Root Canal: Anterior, Bicuspid, Molar

**ENDODONTIC (continued):**

	<u>Plan GE400</u>	<u>Plan GE600</u>
	<u>Area-2 Central/Northern</u>	
Deductibles	None	None
Lifetime Maximums	None	None
Pulp cap, direct	\$5	\$32
Therapeutic pulpotomy (excluding final restoration)	\$15	\$75
Root Canal Therapy:		
Anterior	\$125	\$270
Bicuspid	\$190	\$325
Molar	\$250	\$425
Apexification initial visit	\$12	\$147

**Limitations:** Endodontic Retreatment of previous root canal therapy is not a covered benefit.

**PERIODONTIC:** Gingivectomy, Muco gingival surgery, Osseous surgery, Sub-gingival scaling, Full mouth debridement, Perio maintenance

Deductibles	None	None
Lifetime Maximums	None	None
Gingivectomy (per quadrant) (including post-surgical visits)	\$90	\$243
Gingivectomy, treatment (per tooth-fewer than six (6) teeth)	\$15	\$84
Osseous surgery (per quadrant)	\$250	\$425
Subgingival scaling, root planing (per quadrant)	\$45	\$95
Full mouth debridement	\$45	\$70
Perio maintenance procedure (following active therapy)	\$45	\$55

**Limitations:** Benefits for periodontal scaling and root planing, gingival curettage, and periodontal maintenance procedures, are limited to one (1) course of therapy during any twelve (12) month period.

**PROSTHODONTICS:** Dentures and Partials, Denture and partial repair

Deductibles	None	None
Lifetime Maximums	None	None
Complete denture (upper or lower)	\$275*	\$575
Immediate denture (upper or lower)	\$330*	\$625
Partial-Acrylic base (upper or lower) (including any clasps and rests)	\$215*	\$475

**PROSTHODONTICS (continued):**

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**Area-2 Central/Northern**

Partial-cast metal base with acrylic saddles (upper or lower) (including any conventional clasps and rests)	\$275*	\$625
Adjust denture (upper or lower)	\$8	\$34
Rebase denture	\$75	\$216
Chairside reline of full denture	\$33	\$145
Laboratory reline of denture	\$70	\$183
Interim partial denture	\$80	\$250
Special tissue conditioning per denture	\$20	\$70
Repair denture base	\$30	\$77
Repair missing/broken teeth, denture (per tooth)	\$22	\$68
Repair partial (resin base)	\$28	\$76
Repair partial (framework)	\$44	\$86
Repair or replace clasp	\$44	\$97
Replace tooth (partial)	\$22	\$64
Add tooth to existing partial	\$22	\$91
Add clasp to existing partial	\$50	\$111

**\*Subject to a six (6) month waiting period**

**Limitations:** The replacement of lost or stolen dentures, crown and bridge work, dental procedures and charges incurred as part of implants (placement or removal) and prosthetic devices placed on implants (fixed or removable, for example: bridges, crowns) are not covered.

**ORAL SURGERY: Extractions**

Deductibles	None	None
Lifetime Maximums	None	None
Uncomplicated single tooth (including post-operative visit)	\$15	\$56
Each additional tooth	\$15	\$53
Root removal (exposed)	\$15	\$73
Surgical removal of erupted teeth (including post-operative care)	\$25	\$107
Soft tissue impaction	\$40	\$122
Partial bony impaction	\$60	\$155
Complete bony impaction	\$75	\$198
Removal of residual root covered by bone	\$25	\$114

**Limitations:** Treatment of temporomandibular joint (TMJ), hormonal imbalances, cleft palate, micrognathia, macroglossia and myofunctional therapies are not covered.

**ELECTIVE SERVICES: Elective crowns**

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**Area-2 Central/Northern**

Deductibles	None	None
Lifetime Maximums	None	None
Other elective procedures:		
Elective crown (porcelain with base metal)	\$420	\$420
Labial veneers (porcelain laminate)	\$425	\$425
Bleaching (per arch)	\$175	\$175

**ORTHODONTICS:**

	Plan GE400		Plan GE600	
	Child	Adult	Child	Adult
Banded Comprehensive (full upper and lower)	\$2,100	\$2,250	\$2,200	\$2,400
Banded Limited (upper or lower)	\$1,450	\$1,550	\$1,450	\$1,550
Retention (upper or lower)	\$175	\$175	\$175	\$175
Consultation fee (no other services to be performed)	\$45	\$45	\$45	\$45

**Limitations:** Study models, x-rays and extractions for ortho purposes, tracings, photographs, and Phase 1 ortho (prior to full mouth banding), treatment started prior to coverage, severe or mutilated malocclusions, and retreatment of ortho cases are not covered.

**GENERAL SERVICES: Local anesthesia, treatment of post surgical complication**

Deductibles	None	None
Lifetime Maximums	None	None
Local anesthesia	No charge	No charge
Office visit for observation.	\$5	\$20
Treatment of post-surgical complications	No charge	No charge
Occlusal guard - Athletic	\$140	\$140
Occlusal adjustment - limited (per visit)	\$12	\$65

**Limitations:** General anesthesia, inhalation sedation, intravenous sedation, and intramuscular sedation are not covered.

Plan contribution towards the cost of specialty care as a result of an approved referral is limited to a maximum of \$500.00 per contract year, \$2,000.00 lifetime on plan GE600, and \$1,000.00 maximum with \$2,000.00 lifetime on plan GE400.

<b>OUTPATIENT SERVICES:</b>	Not covered
<b>HOSPITALIZATION:</b>	Not covered
<b>AMBULANCE SERVICE:</b>	Not covered
<b>PRESCRIPTION DRUG SERVICES:</b>	Not covered
<b>DURABLE MEDICAL EQUIPMENT:</b>	Not covered
<b>MENTAL HEALTH EQUIPMENT:</b>	Not covered
<b>CHEMICAL DEPENDENCY SERVICES:</b>	Not covered
<b>HOME HEALTH SERVICES:</b>	Not covered

Dental with Vision Care is also available. Please consult the Vision Disclosure for Co-payment Fees.

**PREPAYMENT FEES FOR DENTAL ONLY**

Plan GE400 Dental	Monthly*	Annual
Member only	\$17.00*	\$193.00
Member & one (1)	\$25.20*	\$289.00
Family	\$34.50*	\$398.00
Plan GE600 Dental	Monthly*	Annual
Member only	\$6.65*	\$70.00
Member & one (1)	\$10.40*	\$115.00
Family	\$13.00*	\$141.00

\*Includes a 50¢ monthly service charge

In addition to your first month's payment there is a one-time only, non-refundable application fee of \$16.

The SmileSaver Dental Plan (the "Plan") shall not increase the premium to the Member except after a period of at least thirty (30) days from and after postage paid mailing to the Member's address of record with the Plan explaining the proposed increase in premium.

If the Subscriber's payment for premium results in a lack of payment due to any banking issue, that is not the responsibility of the Plan, then the Plan may impose a service charge not to exceed \$15.

**CHOICE OF DENTISTS AND PROVIDERS:** Each Member and eligible dependent must use his/her participating dental office. Each family can select up to three (3) different dental offices (one dentist per Member). The Member and each covered dependent may obtain his/her covered services only from his/her designated participating dental office.

**PROVIDER INCENTIVE:** The Plan compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount of money each month based upon the number of

Members that select their office. The dentists also receive compensation from Members, who pay a defined "co-payment" for specific dental services. These are the only forms of compensation the Participating General Dentist receives. The summary of co-payments is located in this Disclosure Form. If you would like more information regarding the Plan's provider incentive programs, please contact the Plan's Professional Network Service Department at (800) 333-9561.

**LIABILITY OF SUBSCRIBER AND MEMBER FOR PAYMENT:** By statute, every contract between the Plan and a provider must provide that, in the event the Plan fails to pay the provider any sums which the Plan owes to the provider, the Member will not be liable to the provider for payment of any such amount. If the Plan fails to pay a non-contracting provider, the Member may be liable to the non-contracting provider for the cost of services received by that Member.

**FACILITIES:** Participating Dentists are available for non-emergency care during their regular office hours. Emergency care is available on a 24-hour basis.

**EMERGENCY HEALTH COVERAGE:** Plan Members can be reimbursed up to \$50 for emergency dental services while more than 50 miles away from the Member's participating dental plan provider. Proof of receipt of such services must be submitted to the Plan in writing. Emergency care is available on a 24-hour basis. Members are encouraged to use appropriately the "911" emergency response system in areas where the system is established and operating when they have an emergency medical condition that requires an emergency response.

**RENEWAL PROVISIONS:** The Subscriber may renew coverage at the prevailing rate and for the benefits available at the time the Evidence of Coverage-Contract of Benefits expires. Notice of rates and benefits available will be mailed to the Member thirty (30) days prior to the expiration of the Evidence of Coverage-Contract of Benefits.

The Plan is prohibited from decreasing in any manner the benefits referred in the Evidence of Coverage-Contract of Benefits, except after a period of at least thirty (30) days from and after the postage paid mailing to the Subscriber at the Member's address of record

with the Plan of written notice of any proposed change in benefits.

**TERMINATION OF BENEFITS DISENROLLMENT:**

After the date on which termination becomes effective, the Participating Dentist will complete any "service in progress" as defined in Part I of the Evidence of Coverage-Contract of Benefits. Benefits shall cease upon: (a) written notice of voluntary cancellation by subscriber, which must be submitted to Greater California Dental Plan thirty (30) days prior to the effective date of the cancellation, (b) the date of expiration of the Evidence of Coverage-Contract of Benefits, if not renewed, (c) notice to the Member that a satisfactory dentist-patient relationship cannot be established, or (d) upon a dependent attaining the age of 19 (or 23, if a full-time student) or upon dependent's marriage. For reasons b, c and d, notice of such termination shall be made in writing by the Plan and coverage shall cease fifteen (15) days after receipt of the postage paid mailing of such notice. Following termination, the Plan will, within thirty (30) days, refund a pro-rata share of the premium balance of the coverage period from the date of termination. If coverage lapses from non-renewal while a Member is hospitalized, the Plan has a thirty (30) day grace period for full reinstatement of coverage without a lapse in coverage.

**REVIEW OF PROCEDURE CODES; QUESTIONS ON COVERED BENEFITS:**

The Plan first determines if the Member is eligible by verifying if the enrollment requirements and premiums were paid for a given period of time in which services are to be delivered. The Plan then verifies that the Member is seeking care at a participating office. Finally, if there is a question as to the scope of coverage, the Plan reviews the procedure codes of the proposed treatment and compares them to the ones listed in the Evidence of Coverage-Contract of Benefits. Additionally, the list of exclusions and limitations of the given program are reviewed to see what effect they may have upon the proposed treatment with respect to coverage. The Plan then informs the Member and the dentist of its findings.

The Plan does not approve, modify or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to members based, in whole or in part, on whether the health care services are medically necessary.

**GRIEVANCE PROCEDURE:** It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under the Evidence of Coverage-Contract of Benefits were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to

arbitration, as provided by California law, and not by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. The Plan and the Member, by entering into such agreement, 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.

**CONTINUITY OF CARE:** If a Member is in a course of treatment for an acute condition or serious chronic condition, he or she may be entitled to stay with his/her current provider up to ninety (90) days and conditioned upon the provider agreeing to the same contract conditions as prior to his/her termination from the Plan network. The provider is not obligated to agree to continue the delivery of care under the terms of the terminated contract. Please call the Plan at (800) 333-9561 to see if you are eligible for this benefit.

**MEDICAL RECORDS: A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.**

**LOSS-RATIO NOTICE FOR INDIVIDUALS OR GROUPS OF 25 OF LESS:**

This is to advise you that health care costs for Plan GE600 for fiscal year ended December 31, 2000, were 7%. The health care costs for Plan GE400 were 58% for fiscal year ended December 31, 2000.

***WHEN WILL BENEFITS BEGIN?***

Those who enroll before the 20th of the month will begin coverage the first day of the following month. Coverage for those who join after the 20th will begin on the first day of the second month thereafter.