Pre-paid Dental HMO Plan

Welcome to a plan with values

Golden West Dental & Vision is a California specialized health care service plan. We believe in preventive dental care. Our goal is to bring you and your family to a better level of dental health. And to help you keep this level without high premiums.

An ounce of prevention

Preventive and basic services are offered at little or no cost. You are encouraged to maintain great dental health.

How does the plan work?

Simply fill out the enclosed enrollment form. Be sure to list the plan dental office you select. Upon enrollment, you will get a membership card. This card includes the name and phone number of your dentist. To make an appointment, call the dental office. Explain that you are a member of Golden West Dental & Vision. All services must be given by your selected provider.

When do the benefits take effect?

Benefits begin on the 1st of the month after receipt of a filled out enrollment form. Enrollment forms must be received by Golden West Dental & Vision before the last day of the month to make sure you can join on the 1st of the next month.

Who can join?

California residents and their eligible dependents (your spouse and children to the age of 26).*

* Dependent maximum age may vary. Get in touch with your employer for full details.

Expansive network

As a plan member enrolled in the Golden West dental program, you can get dental care through a network of more than 6,000 dentists and specialists.

This brochure is only an overview of the dental plan. The dental plan Evidence of Coverage lists all the terms, limitations and exclusions of coverage. You have a right to look at a sample Evidence of Coverage before enrollment. Sample copies can be obtained by calling Golden West Customer Service.

The Evidence of Coverage should be read fully and carefully. If you have special dental care needs, you should carefully read the sections that applies to you. If you have any questions or need more help, please call the phone number on your ID card.

The dental plan benefits and uniform matrix for your specific plan is located on the insert included with this brochure.

Selecting a dentist

Each participating dentist has undergone the Golden West credentialing process. This ensures that all participating dentists meet our participation guidelines. You may choose any participating dentist to receive dental services covered under your plan.

Visit goldenwestdental.com and use our Provider Finder tool:

- Select Provider Finder (top right of home page)
- Select Dental HMO/Pre-paid Plans
- Redirected to the WellPoint website
- Follow the prompts to select a Network Provider

GOLDEN WEST
DENTAL & VISION

Making an appointment
To make an appointment, you should phone your selected dental office (see ID card). Most visits will be during normal business hours, Monday through Friday. Some participating offices offer evening and/or weekend hours. Check hours with the office selected.

May I change dentists?
You may change your dentist by contacting the Golden West Member Service Department. You must do this before the last day of the month. You may receive covered services at your new dental office on the 1st of the next month. This request may be made in writing or by calling our Member Service Department. In the event you still owe your dentist or you are in the middle of care, you may not change offices until all unpaid balances are paid in full or care is done. The plan reserves the right to reassign you, at any time, to another office.

What if I miss my appointment?
Scheduled visits must be cancelled at least 24 hours before the appointment time.

When do I have to pay for services?
Your copays are due when care is given.

Are lab fees an extra cost?
Lab fees are paid as well as the copay. Your dentist makes an impression and sends it to a dental lab where the crown or prosthetic is made. The dental lab charges the dentist to make the crown or prosthetic. You are responsible for the dental lab fee. You are also responsible for the crown, bridge or prosthetic copay. The copay is the dentist's fee for the procedure.

How much can I save?
Your copay is based on a reduced fee from your dentist's normal fee. The savings can be as high as 100%.

For Example:*

	Copay	Typical Dentist Charge
X-ray	No charge	$64
Periodic Exam	No charge	$53
Amalgam	No charge	$144
Porcelain Crown with Metal (Anterior)**	$120	$1,005
Root Planing, per Quad	$20	$223
Single Root Canal	$50	$1,007

* Example based on Plan 89L Level 3.

** Plus actual dental lab fee. Dentist will charge the lab fee, as well as your copay.

Is there an annual maximum?
No annual maximums apply to your general dental benefits. Therefore, Golden West does not limit the dollar amount of coverage you can get from your selected provider.

Does per surface mean per tooth?
There are up to five surfaces per tooth that can be restored by amalgam (silver) or composite (tooth-colored) fillings. The copay, if any, is charged per surface.

What if I need a specialist?
Usually all of your plan benefits can be performed by the plan general dentist. But, if your dentist feels your condition calls for treatment by a dental specialist, the dentist will send you to Golden West for specialty referral. Ask your benefit manager or employee representative if your group has orthodontic or specialty coverage. Annual and lifetime maximums may apply. You may also call the phone number on your ID card.

What if I have an emergency?
An emergency is defined as acute oral pain, infection or bleeding. A dental emergency is treated by relieving the pain, treatment of infection or stopping the bleeding. Call your Golden West dentist. Each Golden West dental office has a 24-hour number listed on your membership card.

Coordination of benefits
Coordination of benefits will be in compliance with the Knox-Keene Act. If you have two or more plans, your benefits will not go over 100% of your charges.

How do I renew my coverage?
Prior to renewal, Golden West will inform your employer of any changes in fees or benefits.

What if I have a complaint?
If you have a complaint about a dentist, staff, office or Golden West, please write to us or call us. We want to know so that we can fix the problem.

Cancellation or termination
Benefits shall end upon the events below:

A. On the group termination date
B. Non-payment of premiums or copay due shall end all future benefits to subscriber/group. If the group is terminated before end of coverage period, you are subject to the dental office normal charges for any services performed under the plan.
C. Fraud or deception in the use of plan dentists. Knowingly permitting such fraud or deception by another
D. After a reasonable attempt to form and maintain satisfactory provider-patient relationship fails with any subscriber or enrollee, coverage will be terminated as of the last day of the month during which the plan gives a notice of cancellation.

If your benefits are cancelled by Golden West, or by your group, Golden West shall return the pro rata part of any money paid to us. This corresponds to any unexpired period for which payment has been received. This money will be returned to you or the group within 30 days of cancellation. It will include any amounts due on claims, if any, less any amounts owed to Golden West. An exception to this is cancellation due to

event (b) above. In the event your dependent's coverage ends through a qualifying event, see employer about continuation of coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).

Definitions

ADA – American Dental Association.

Benefits – Services given under the group coverage.

Copay – Extra fees needed under the plan for specific services. These fees are paid by you directly to the provider.

Dependent – Spouse of subscriber and/or children to age 26. Children who have a mental or physical handicap and are chiefly dependent upon the subscriber for support may be eligible for extended coverage. Proof of such continuing dependency must be sent to Golden West upon request. If your group has negotiated special dependent age requirements, the group will prevail. Special dependent definitions may apply as determined by both the group and Golden West.

Group – Organization or employing unit with which subscriber is associated and which has a Golden West group plan.

Member – Any subscriber or eligible family dependent entitled to get services under a Golden West group plan.

Non-Panel Provider – A licensed professional not under contract with Golden West.

Provider – A licensed professional who gives services to you and with whom Golden West has contracted. Used interchangeably with facility.

Service Area – Urban geographic areas within a 30-mile radius from any Golden West general dentist and within a 50-mile radius from any Golden West specialist. Rural geographic areas within a 60-mile radius from any Golden West general dentist and within a 100-mile radius from any Golden West specialist.

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

Subscriber – Person 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 ended.

Limitations

A. General
1. Dental treatment must be received from your participating dental office unless specifically authorized in writing by plan.
2. Participating providers shall have the right to discontinue further treatment of a member who continually fails to keep appointments or who fails to follow their prescribed course of treatment.

B. Diagnostic/Preventive
1. Routine and periodic examinations are limited to once every six months.
2. Prophylaxis (teeth cleaning) is limited to once every six months.
3. Bitewing radiographs (X-rays), in conjunction with periodic exams, are limited to one series of films in any 12 consecutive-month period.
4. Full mouth radiographs (X-rays) and Panorex are limited to once every three years.
5. Fluoride treatment is limited to once every 12 months.
6. Sealants are allowed in permanent first and second molars up to the age of 16.

C. Restorative/Crowns
1. Space maintainers are allowed only for dependent children up to the age of 16.
2. Stainless steel crowns on permanent teeth are allowed up to the age of 19.
3. Temporary restorations, all adhesives (including amalgam bonding agents), liners and bases, impressions and local anesthesia are considered components of the fee for the completed restoration.
4. Benefits for the treatment of rampant caries are limited to the first seven most severely decayed primary teeth, subject to all plan limitations. Rampant caries is defined as eight or more decayed primary teeth.
5. 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.
6. The use of noble and high noble metal for any restorative procedure will be charged to you at the additional laboratory cost of the noble or high noble metal. Copays do not include charges for gold or dental laboratory fees.

D. Prosthodontics
1. Complete and/or partial denture relines are limited to one per denture during any 12-month period.
2. Complete or partial upper and/or lower dentures are limited to the benefit level for a standard procedure. If a more personalized or specialized treatment (such as precision attachments, overlays, implants, personalization or characterization) is chosen by you and the dentist, you will be responsible for all additional charges.
3. 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.

E. Periodontal
1. Gingival curettage, periodontal scaling and root planing are limited to four quadrants per calendar year if periodontal disease is present. No more than two quadrants per service date are allowed.
2. Osseous surgery is limited to four quadrants per lifetime.
3. One treatment of actisite for replacement of fiber material is allowed within10 days of initial placement.

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, health insurance, workers' 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.
5. Treatment rendered by a specialist if member is deemed unmanageable for treatment by any network general dentist, except for covered dependent children up to the age limit stated on Specialty Referral Exhibit D if specialty care is included.
6. Conditions resulting from disease or epidemic or injuries sustained as a result of a major disaster or war (declared or undeclared).
7. Dental procedures initiated prior to your eligibility under this benefit plan or started after your termination from the plan.
8. Services performed for cosmetic, elective or aesthetic purposes, unless the policy includes a cosmetic/elective benefit rider.
9. Dental laboratory fees including the cost of noble and high noble metal.
10. 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.
11. Implants and services incurred as part of implants, and fixed or removable prosthetics placed on implants.
12. Treatment related to temporomandibular joint syndrome (TMJ).
13. 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 thumb-sucking devices)
14. 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.
15. General anesthesia, analgesia (including nitrous oxide), sedation and prescription drugs.
16. Any inpatient/outpatient hospital or surgicenter charges of any kind including physician charges, prescriptions or medication.
17. Treatment for crown exposure, ligation and crown lengthening.
18. Replacement of an appliance or fixed or removable prosthetic with a like appliance or prosthetic unless the appliance or prosthetic is at least five years old and cannot be made usable. Replacement of crowns unless existing crown is more than five years old.
19. Replacement of a lost, stolen or missing appliance, or prosthetic device, glasses or contacts.
20. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive dental rehabilitation or reconstruction (six or more units of crown and/or bridgework in one arch or more than 10 units total).
21. Resectioning of the bone and surgeries involving repositioning of the teeth or tooth implantation, re-implantation or transplantation.
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 that appear to be at or near exfoliation.
24. Orthodontic treatment unless specifically included. Under any applicable orthodontic benefits, treatment plans started before you enrolled with the plan are not covered.