

<b>WELCOME TO SMILESAVER!</b>		
Principal Benefits and Coverage, Principal Exclusions and Limitations on Benefits and Other Charges are contained in the following Matrix.		
<b>PLANS SM400/SM600 SOUTHERN CALIFORNIA</b>		
<b>This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Evidence of Coverage should be consulted for detailed description of coverage benefits and limitations.</b>		
<b>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.</b>		
<b>PROFESSIONAL SERVICES</b>		
Co-payments listed are for services performed by your assigned participating general dentist.		
<b>PREVENTIVE:</b> Comprehensive and periodic oral exam, oral hygiene instruction, X-rays, sealants		
	<b>SM400</b>	<b>SM600</b>
Deductibles	None	None
Lifetime Maximums	None	None
Comprehensive oral exam	\$4	\$4
Periodic oral exam	\$4	\$4
Pulp vitality testing	\$0	\$0
Oral hygiene instruction	\$0	\$0
X-rays	\$5	\$5
Sealants (per tooth)	\$10	\$12
Fluoride Treatment (child)	\$5	\$5
<b>PROPHYLAXIS:</b> Routine cleaning		
Deductibles	None	None
Lifetime Maximums	None	None
Prophylaxis - adult or child	\$0	\$22
<b>Limitations:</b> Benefits for prophylaxis procedures are limited to once every six (6) months.		
<b>RESTORATIVE:</b> Fillings (amalgam and resin restorations), crowns, post and core, bridges		
Deductibles	None	None
Lifetime Maximums	None	None

<b>RESTORATIVE (continued):</b>		
	<b>SM400</b>	<b>SM600</b>
Amalgam restorations (adult & children's teeth):		
Fillings (1 surface)	\$10	\$36
Fillings (2 surfaces)	\$15	\$47
Fillings (3 surfaces)	\$24	\$55
Fillings (4 or more surfaces)	\$28	\$68
Resin restorations (anterior/front teeth):		
Resin (1 surface)	\$22	\$49
Resin (2 surfaces)	\$28	\$60
Resin (3 surfaces)	\$33	\$75
Resin (4 or more surfaces)	\$39	\$94
Other restorative procedures:		
Sedative filling	\$0	\$31
Crown build-up (including pins)	\$0	\$82
Pin retention (per tooth)	\$0	\$18
Crowns and Bridges including pontics:		
Porcelain with metal (anterior tooth)	\$190*	\$400
Full cast (metal)	\$150*	\$360
3/4 cast (metal)	\$155*	\$395
Stainless steel (child)	\$44	\$82
Stainless steel (adult)	\$44	\$95
Cast endo post and core (in addition to crown)	\$50	\$130
Prefabricated endo post & core (in addition to crown)	\$30	\$100
Core build-up for retainer (including pins)	\$25	\$87
Recementation:		
Inlay	\$13	\$30
Crown	\$13	\$30
Bridge	\$20	\$46
*Subject to a six (6) month waiting period.		
<b>Limitations:</b> 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.		
<b>ENDODONTIC:</b> Pulp cap, pulpotomy, root canal: anterior, bicuspid, molar		
Deductibles	None	None
Lifetime Maximums	None	None
Pulp cap, direct	\$5	\$24
Therapeutic pulpotomy (excluding final restoration)	\$15	\$53
Root canal therapy:		
Anterior	\$110	\$230
Bicuspid	\$165	\$285
Molar	\$220	\$400
Apexification, initial visit	\$12	\$105
<b>Limitations:</b> Endodontic retreatment of previous root canal therapy is not a covered benefit.		

<b>PERIODONTIC:</b> Gingivectomy, osseous surgery, scaling and root planing, full mouth debridement, perio maintenance		
	<b>SM400</b>	<b>SM600</b>
Deductibles	None	None
Lifetime Maximums	None	None
Gingivectomy (4 or more teeth per quadrant)	\$85	\$215
Osseous surgery (4 or more teeth per quadrant)	\$225	\$375
Periodontal scaling and rootplaning (4 or more teeth per quadrant)	\$40	\$85
Full mouth debridement	\$28	\$57
Perio maintenance procedure (following active therapy)	\$33	\$46
<b>Limitations:</b> Benefits for periodontal scaling and root planing and periodontal maintenance procedures are limited to one (1) course of therapy during any twelve (12) month period.		
<b>PROSTHODONTICS:</b> Dentures and partials, denture and partial repair		
Deductibles	None	None
Lifetime Maximums	None	None
Complete denture (upper or lower)	\$250*	\$475
Immediate denture (upper or lower)	\$300*	\$525
Partial - acrylic base (upper or lower - including any clasps and rests)	\$195*	\$375
Partial - cast metal base with acrylic saddles (upper or lower - including any conventional clasps and rests)	\$250*	\$525
Adjust denture (upper or lower)	\$8	\$26
Rebase denture	\$75	\$175
Chairside reline of full denture	\$33	\$110
Laboratory reline of denture	\$70	\$150
Interim partial denture	\$80	\$200
Special tissue conditioning, per denture	\$20	\$55
Repair denture base	\$30	\$57
Repair missing/broken teeth, denture - per tooth	\$22	\$52
Repair partial (resin base)	\$28	\$57
Repair partial (framework)	\$44	\$80
Repair or replace clasp	\$44	\$75
Replace tooth (partial)	\$22	\$52
Add tooth to existing partial	\$22	\$67
Add clasp to existing partial	\$50	\$83
*Subject to a six (6) month waiting period.		
<b>Limitations:</b> 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.		

<b>ORAL SURGERY:</b> Extractions		
	<b>SM400</b>	<b>SM600</b>
Deductibles	None	None
Lifetime Maximums	None	None
Uncomplicated single tooth	\$15	\$44
Surgical removal of erupted teeth	\$25	\$83
Soft tissue impaction	\$40	\$95
Partial bony impaction	\$60	\$132
Complete bony impaction	\$75	\$170
Removal of residual root covered by bone	\$25	\$90
<b>Limitations:</b> Treatment of temporomandibular joint (TMJ), hormonal imbalances, cleft palate, micrognathia, macroglossia and myofunctional therapies are not covered.		
<b>ELECTIVE SERVICES:</b> Cosmetic services		
Deductibles	None	None
Lifetime Maximums	None	None
Posterior resin fillings (1 surface)	\$66	\$65
Posterior resin fillings (2 surfaces)	\$94	\$85
Posterior resin fillings (3 surfaces)	\$110	\$110
Labial veneers (porcelain laminate)	\$400	\$400
Bleaching (per arch)	\$175	\$175
<b>ORTHODONTICS: (ADULT)</b>		
Banded Comprehensive (full upper and lower)	\$2,400	\$2,400
Banded Limited (upper or lower)	\$1,550	\$1,550
Retention (upper or lower)	\$175	\$175
Consultation fee (no other services to be performed)	\$40	\$40
<b>Limitations:</b> 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.		
<b>ORTHODONTICS: (CHILD)</b>		
Banded Comprehensive (full upper and lower)	\$2,200	\$2,200
Banded Limited (upper or lower)	\$1,450	\$1,450
Retention (upper or lower)	\$175	\$175
Consultation fee (no other services to be performed)	\$40	\$40
<b>Limitations:</b> 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.		
<b>GENERAL SERVICES:</b> Local anesthesia, treatment of post surgical complication		
Deductibles	None	None
Lifetime Maximums	None	None
Local anesthesia	\$0	\$0

<b>GENERAL SERVICES (continued):</b>		
	<b>SM400</b>	<b>SM600</b>
Office visit for observation	\$5	\$6
Treatment of post-surgical complications	\$0	\$0
Occlusal guard - athletic	\$140	\$135
Occlusal adjustment - limited (per visit)	\$12	\$40
<b>Limitations:</b> 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 limited to a maximum of \$500 per contract year.		
<b>OUTPATIENT SERVICES:</b>	<b>Not covered</b>	
<b>HOSPITALIZATION:</b>	<b>Not covered</b>	
<b>AMBULANCE SERVICE:</b>	<b>Not covered</b>	
<b>EMERGENCY DENTAL SERVICES:</b>	Up to \$50 for emergency dental services rendered more than 50 miles from Member's participating provider	
<b>PRESCRIPTION DRUG SERVICES:</b>	<b>Not covered</b>	
<b>DURABLE MEDICAL EQUIPMENT:</b>	<b>Not covered</b>	
<b>MENTAL HEALTH EQUIPMENT:</b>	<b>Not covered</b>	
<b>CHEMICAL DEPENDENCY SERVICES:</b>	<b>Not covered</b>	
<b>HOME HEALTH SERVICES:</b>	<b>Not covered</b>	
<b>PREPAYMENT FEES:</b>		
<b>Plan SM400</b>	<b>Monthly</b>	<b>Annual</b>
<b>Members only</b>	<b>\$17.00</b>	<b>\$193.00</b>
<b>Members &amp; one (1) Family</b>	<b>\$25.20</b>	<b>\$289.00</b>
	<b>\$34.50</b>	<b>\$398.00</b>
<b>Plan SM600</b>	<b>Monthly</b>	<b>Annual</b>
<b>Members only</b>	<b>\$6.65</b>	<b>\$70.00</b>
<b>Members &amp; one (1) Family</b>	<b>\$10.40</b>	<b>\$115.00</b>
	<b>\$13.00</b>	<b>\$141.00</b>
Monthly fees include a 50¢ service charge. In addition to your first month's payment there is a one-time only, non-refundable application fee of \$16.		
SmileSaver ("the Plan") shall not increase the prepayment fee to the Member except after a period of at least thirty (30) days from and after postage paid mailing to the Members address of record with the Plan explaining the proposal increase in prepayment fees.		

If the Subscriber's payment for prepayment fees 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 or her covered services only from his or 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 schedule of co-payments is located in the Evidence of Coverage. 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 fifty (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.

**CHANGE IN BENEFITS:** The Plan is prohibited from decreasing in any manner the benefits referred to 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 Subscriber'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 "services in progress" as defined in Part I. Benefits shall cease upon the first to occur of the following: a) The date of expiration of the Evidence of Coverage-Contract of Benefits, if not renewed. b) The date of expiration of the period for which the last prepayment fee was paid, subject to compliance with notice requirements. The prepayment fee is due on the 20th day of the month for coverage during the following month, and is delinquent if not paid on the due date. If the prepayment fee is delinquent, Plan may give written notice to the Member that said prepayment fee is past due. Fifteen (15) days after the delinquency date, if the prepayment fee has not been paid, the Plan may, at its option, terminate the Evidence of Coverage-Contract of Benefits by giving written notice of termination to the Member. Said termination becomes effective on the 15th day following receipt of postage paid mailing to the Member. c) The Plan reserves the right to terminate the Membership contract of a Member if the Plan is unable, after a reasonable effort, to establish and maintain a satisfactory dentist-patient relationship between a Participating Dentist and that Member. Notice of such termination must be in writing by the Plan and coverage shall cease fifteen (15) days after receipt of postage paid mailing of such notice. Following termination, the Plan will refund any prepayment fee received by it on behalf of such Member during the period of one (1) month prior to such termination. d) On the last day of the month for which a prepayment fee payment was made by or on behalf of a Member who is no longer eligible for benefits. e) Upon a dependent's attaining the age of nineteen (19) (or twenty-three (23) if a full-time student), marriage, or otherwise becoming ineligible as defined in Part I. f) A thirty (30) day written notice by the Subscriber to the Plan requesting a voluntary cancellation effective on the 30th day of such a notice. In the event of cancellation, the Member will be returned a pro-rata portion of the prepayment fee paid with the pro-rata portion return computed from the end of the thirty (30) day notice of cancellation period. Enrollment fees are non-refundable. g) In the event the proper prepayment fee amount is paid after cancellation of the Member, the Plan shall reinstate

the Member without requiring a new application unless the Plan shall, within twenty (20) business days: 1) refund the payment made or 2) issue to the other party (Member) a new contract accompanied by written notice stating the differences between the new contract and the terminated contract with regards to benefits, coverage, or otherwise. h) Cancellation by the Plan pursuant to a "notice of cancellation" for good cause other than failure to pay prepayment fee will become effective fifteen (15) days from the date which said notice of cancellation is mailed. i) Upon termination or notice of termination, the Member may request that the cancellation be reviewed by the Commissioner of the Department of Managed Health Care. j) If coverage lapses from non-renewal, while a Member is hospitalized or undergoing treatment for an ongoing condition, 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. 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 PROCEDURES:** A full explanation of how to file a grievance will be provided to you upon enrollment.

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 **(1-800-880-1800)** 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.

In the event of an urgent grievance, which involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, you are not required to participate in the Plan's grievance process and may directly contact the California Department of Managed Health Care, as referenced above, for review of the urgent grievance.

**SECOND OPINIONS:** A member may request a second opinion (to request additional treatment currently recommended) by calling or writing the Plan at: SmileSaver, - Second Opinion, 95 Enterprise, Suite 100, Aliso Viejo, California, 92656-2605. If the Plan believes a second opinion is needed, the Plan will arrange for the second opinion and the Member will be responsible for the applicable co-payment, if any. If a second opinion is not believed to be necessary by the Plan, the Member can obtain a second opinion from a Plan provider for a specified copayment or can obtain a second opinion from any non-participating provider at the Member's sole expense. If the Member does not agree with the Plan's position regarding the denial of a second opinion, the Member may file a grievance against the Plan utilizing the Plan's grievance procedure described in the Evidence of Coverage.

**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.**

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

#### 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.

#### IT'S EASY TO JOIN

1. Use the enrollment form enclosed. Fill in your name, address, and the information requested about you and all dependents you want to cover.
2. Choose your method of payment by marking the appropriate box on the attached enrollment form. If you choose annual payment, enclose a check or money order made payable to SmileSaver or provide your credit card information. If you choose monthly payment using the Automatic Payment Authorization select either credit card billing (provide credit card information) or automatic checking account deduction. For automatic checking account deductions, enclose a check which includes the first month's premium plus the one-time, nonrefundable \$16 enrollment fee. All future payments will be deducted from your checking account.
3. Sign your name in Section 7 Acknowledgement to authorize enrollment.
4. Make sure all requested information has been provided and that the application is signed. Then mail.

Southern California Zip Code List of Participating Dentists. This Plan includes participating dentists in the following zip codes: 90000-90299, 90500-90699, 91200-91399, 91600-91899, 92000-92099, 92500-92699, 92800-92899, 93000-93099, and 93500-93599. For services needed by a Plan Dentist outside your local area, different co-payments may apply.
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Southern California includes participating dentists in the following counties only: Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura. For services needed by a Plan Dentist outside your local area, different co-payments may apply.



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Benefits provided by SafeGuard Health Plans, Inc.

SM-DP-SM4-6-DF-IND-SC-DAIS



Dental Plan  
SM400/SM600

## Disclosure Form

### Southern California Description of Benefits & Co-payments

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 the coverage. You have a right to view the Evidence of Coverage - Contract of Benefits prior to enrollment. A copy is available upon request from SmileSaver. 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.

Individual/Family Dental Plan

SmileSaver, a division of SafeGuard Health Plans, Inc.