GENTLE DENTAL GROUP ADULT AND CHILDREN'S DENTAL PROGRAMS
San Francisco Locals 10, 34, 75 and 91
A Supplemental Summary Plan Description

ELIGIBILITY AND LOSS OF ELIGIBILITY

Gentle Dental Group Adult and Children's benefits are provided by the ILWU-PMA Welfare Plan for all persons with ILWU-PMA Welfare Plan eligibility for dental benefits. This includes active and retired Longshoremen, Ship Clerks, Walking Bosses/Foremen, Watchmen, certain employees of the ILWU, ILWU-PMA Benefit Plans and the ILWU locals, and their qualified dependents. Dependent children are eligible up to age 26. Qualified surviving spouses of active and retired employees are also covered. A full explanation of how eligibility is determined and lost is in the ILWU-PMA Welfare Plan Summary Plan Description.

CHOICE OF PLANS

Eligible persons in the San Francisco area are offered a choice between the Gentle Dental Group Plan and the alternative plans, Delta Dental of California or Dental Health Services. The choice is offered when eligibility is first obtained, and each year in May for coverage effective July 1. In addition to the May open enrollment period, Participants may change their dental plan coverage once at any time during the Plan Year (July 1 – June 30). Information about the choice is furnished by the ILWU-PMA Benefit Plans Office.

HOW TO USE YOUR DENTAL PROGRAM

All dental services are provided at the Gentle Dental Group office at the following location:

2494 Mission Street
San Francisco, CA 94110
(415) 787- 4272

You must go to the office listed above to receive treatment under the Gentle Dental Group Program. The dental office is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Call the above listed number for an appointment; in case of emergency, a visit will be scheduled immediately.

No identification card is necessary, there are no insurance forms to complete, and no prior authorization for treatment is required.

BENEFITS PROVIDED BY THE PROGRAM

The Gentle Dental Group Adult and Children's Programs provide coverage for the diagnostic, preventive and restorative treatment services described below.

Diagnostic: The procedures necessary to assist the dentist in evaluating the existing condition and determining the required dental treatment.

Preventive: Those procedures necessary to prevent the occurrence of oral disease, including prophylaxis (teeth cleaning) as required; fluoride treatment and space maintainers.

Oral Surgery: Extractions and certain other surgical procedures including pre-operative and post-operative care.

General Anesthesia: When required for covered oral surgery performed by a dentist.

Restorative Dentistry: Treatment of tooth decay or fracture by amalgam, synthetic porcelain and plastic restorations or fillings. When necessary, gold restorations, crowns and jackets will be provided.

Endodontic: Treatment of the tooth pulp and root canal filling (treatment of non-vital teeth).

Periodontal: Treatment of the tissues (gums and bones) supporting the teeth.

Prosthodontic: Procedures for construction of bridges, or partial or complete dentures.

In addition to the covered services listed above, the following benefits are provided under the Children's Program only:

Preventive: Sealants. Sealant benefits are limited to dependent children under age 14 only and include the application of sealants only to permanent posterior molars with no caries (decay), with no restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

Orthodontic: Correction of malpositioned teeth. The orthodontic benefit is 90% of the Maximum Allowable Charge (MAC).

EMERGENCY OUT-OF-AREA BENEFIT

Emergency treatment incurred at another dental facility outside a fifty (50) mile radius of the Gentle Dental Group office will be paid by the Gentle Dental Group.

LIMITATIONS

Covered services listed in this brochure are subject to the following limitations:

- Broken appointment charge: The Gentle Dental Group does not charge for the first broken appointment; however, there is a $25.00 charge for each subsequent broken appointment.
- The Gentle Dental Group will cover the total cost of treatment procedures which are customarily provided. However, should you select a more expensive plan or treatment (i.e. a gold crown when a silver restoration could restore the tooth), then the Gentle Dental Group will cover the fee applicable for the lesser procedure and the patient will be responsible for the remainder of the fee.
- Crowns, jackets and gold restorations: Replacement will be made at any time if, in the opinion of the Gentle Dental Group, said crown, jacket or gold restoration is unsatisfactory.
- Prosthodontics: Replacement will be made of a prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances (including but not

limited to partial and complete dentures and fixed bridges) will be replaced only after five (5) years have elapsed following any prior provision of such appliances, except when there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory.

- Occlusion: The Gentle Dental Group will cover the cost of restorations required to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restoring or maintaining the occlusion are considered optional and the cost is the responsibility of the patient. The cost will be that cost which is listed as the Maximum Allowable Charge (MAC) and currently being charged by the Gentle Dental Group to patients not covered by this agreement. Such procedures may include, but are not limited to, equilibration periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.
- Implants: The Gentle Dental Group does not provide benefits for dental implant procedures (appliances inserted into bone or soft tissue) nor the surgical removal of implants. However, the ILWU-PMA Welfare Plan offers a Dental Implant Program Benefit whereby all requests for precertification of dental implants or claims for payments of dental implants will be referred to Medical Review Institute of America (MRIoA). If MRIoA determines that a dental implant procedure is medically necessary, it will be covered at 80% of the average charges in your area, which means that you may be responsible for more than 20% of the billed charges. Information regarding the Dental Implant Program can be obtained by calling the ILWU-PMA Benefit Plans Office.
- The cost of any item or procedure for which the patient might have to pay will be that which is listed as the MAC and currently being charged by the Gentle Dental Group to patients not covered by this agreement.

EXCLUSIONS

The following services are not covered:

- Services covered under Workers' Compensation or similar employer liability laws;
- Services provided without cost by any federal or state government agency, county or municipality except Medi-Cal benefits;
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth);
- Prosthodontic or any other procedures started prior to the date of eligibility for services under this dental program;
- Prescribed drugs;
- Orthodontic services for adults age 19 or over;
- Care otherwise provided under the ILWU-PMA Welfare Plan;
- Experimental procedures;
- All hospital costs;
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

COORDINATION OF BENEFITS – (DUAL COVERAGE)

In order to avoid duplication of payment for the same services, the benefits of the Gentle Dental Program are coordinated with other programs which are not paid for by the member and which provide dental benefits. Generally, if a patient is covered by more than one dental program, expenses are shared between the programs up to the full amount of the actual cost.

CLAIMS REVIEW PROCEDURES

The procedures described below apply to requests for benefits under the dental program. Please note that a mere inquiry about whether a particular item is covered under the Plan is not a claim for this purpose.

Any claim for services or benefits which is denied or partly denied will be reviewed if the claimant or his or her representative so requests. The Gentle Dental Group will notify the claimant if any services are denied, stating the reason for the denial and a description, if appropriate, of additional information or material necessary for the claimant to perfect the claim. Notice of denial of a claim must be given to the claimant within a reasonable period of time, but not more than 30 days after the date the claim is received. This period may be extended an additional 15 days if Gentle Dental Group determines that an extension is necessary due to matters beyond its control and the claimant is notified of the extension before the end of the initial 30-day period and the date by which Gentle Dental Group expects to render a decision on the claim. If an extension is required because the claimant failed to submit sufficient information to enable Gentle Dental Group to make a determination of the claim, the notice of the extension will also describe the additional information required. In such a case, the claimant will be given at least 60 days to provide the additional information. The period from the date the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

If the Gentle Dental Group does not respond to the claimant's claim within the time periods specific above, the claimant may deem his/her claim denied for the purpose as of the expiration of the applicable time period above.

In case of a dental care or treatment plan dispute, the case will be arbitrated by the Peer Review Committee of the Dental Society of San Francisco.

REQUEST FOR CLAIM REVIEW BY TRUSTEES OF THE ILWU-PMA WELFARE PLAN

Within 180 days after notice that a claim has been denied by the Gentle Dental Group, or after the claim is deemed denied as provided above, the claimant or his/her representative may make a written request for a review of the denial by the Trustees of the ILWU-PMA Welfare Plan. Requests for review of a denied Gentle Dental Group claim should be submitted to the Benefit Plans Office. The Claims Review Procedure is described completely in your ILWU-PMA Welfare Plan Summary Plan Description.

The information in this booklet is subject to and does not change the provisions of the ILWU-PMA Welfare Plan Agreement or the provisions of the Welfare Plan Summary Plan Description.