

## VISION PLAN 89E COPAYMENT SCHEDULE

Exhibit B

Vision care treatment must be provided by a current member of the Golden West Vision Panel.

PROCEDURE	MEMBER PAYS	PROCEDURE	MEMBER PAYS
<b>SERVICES</b>		<b>CONTACT LENSES (Rigid)</b>	<b>Cost Per Lens</b>
Visual Analysis	\$ 39.00	Hard Lens (P.M.M.A.)	\$ 30.00
<b>CONTACT LENSES (Soft)</b>	<b>Cost Per Lens</b>	Gas Permeable (Daily Wear)	45.00
<i>Daily Wear</i>		Gas Permeable (Extended Wear)	60.00
Regular Soft	40.00	Bifocal	140.00
Tinted	45.00	Toric	70.00
Toric	70.00	<b>COMPLETE FITTING AND THREE-MONTH FOLLOW-UP, CAREKIT, AND TRAINING FOR CONTACT LENSES</b>	
Tinted Toric	80.00	<i>Daily Wear</i>	
Custom Toric	105.00	Regular Soft, Tinted, Thin, or Hard	45.00
Aphakic (Post Cataract)	80.00	Disposable & Frequent Replacement	45.00
Opaque	65.00	<i>All Others</i>	
Toric Opaque	95.00	Toric, Extended Wear, Bifocal, Gas Permeable, Monovision, or Aphakic (Post Cataract)	112.00
Bifocal	100.00	<b>FRAMES AND LENSES</b>	
Super Thin	40.00	Lenses (All sizes)	25% Discount*
<i>Extended Wear</i>		Frames (All sizes)	25% Discount*
Regular Soft	40.00	Eyeglass Case (with purchase of eyeglasses)	No Charge
Tinted	45.00	Eyeglass Adjustments (with purchase of eyeglasses)	No Charge
Toric	85.00	Sunglasses	25% Discount*
Aphakic (Post Cataract)	90.00		
<i>Disposable &amp; Frequent Replacement</i>	10% Discount*		

### LIMITATIONS AND EXCLUSIONS

1. Medical Eye services will be excluded from optometry services.
2. Any procedure not listed on copayment schedule may be available at the Optometrist's Usual and Customary Fees.
3. There will be a charge for broken appointments without notification according to the policy of the optometry office.
4. Follow-up care for contact lenses shall be limited to a period of time not to exceed three (3) months. Additional visits are subject to an office visit charge.
5. Dispensing or prescribing of drugs.
6. Procedures or services determined by the Plan to be special or unusual including, but not limited to, orthoptics, vision training, and subnormal vision aids.
7. Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability Laws. Services which are provided without cost to the member by any municipality, county, or other political subdivision.
8. In the event that patient desires to be hospitalized for any ocular procedure, the cost will be borne by the patient.
9. Treatment required for conditions resulting from major disaster or epidemic or military-service-connected conditions.
10. Any experimental procedures.
11. Services that cannot be performed because of the general health of the patient.

\*Not to be combined with any other offer.

A minor fitting fee of \$30 is applicable in lieu of the complete fitting fee if the patient receives contact lenses elsewhere. Payment is due at time services are rendered.

## ORTHODONTIC PLAN 4 COPAYMENT SCHEDULE

Exhibit C

Treatment must be provided by a current member of the Golden West Orthodontic Panel.

ADA CODE	PROCEDURE	MEMBER PAYS
D8660	<b>Initial Examination</b>	No Charge
D8660	<b>Diagnostic Work-Up</b> Includes consultation, study models and diagnosis on cases where treatment is prescribed. Payable only if patient does not proceed with treatment.	\$ 100.00
D8070/8080	<b>Full Upper and Lower Banded Case - Children to age 19</b>	1,795.00
D8090	<b>Full Upper and Lower Banded Case - Adult*</b>	1,795.00
D8030/8040	<b>Limited Upper or Lower Banded Case (Single Arch)</b>	1,025.00
D8030/8040	<b>Minor Tooth Movement</b>	590.00
D8680	<b>Retainer Visits and Care for 6 Months Following Completion of 24-Month Treatment Period. (Includes cost of retainer appliances)</b>	
	Full Banded Case	200.00
	Limited Banded Case (Single Arch)	100.00
	Minor Tooth Movement	100.00
	<b>Retainer Visits after Initial 6-Month Period (per visit)</b>	15.00
	<b>Broken Appointments (without 24-hour notice)</b>	10.00

### LIMITATIONS AND EXCLUSIONS

1. Treatment must be provided by a current member of the Golden West Orthodontic Panel.
2. Plan benefits include 24 months of standard orthodontic treatment and an additional 6 months of retention. Treatment extending beyond these time periods will be subject to additional charges
3. Treatment in progress at inception of eligibility is not covered.
4. Once an orthodontic treatment plan has begun, you may not change orthodontic providers.
5. Subscriber and his/her eligible dependent must remain on the plan during the period of time subscriber or dependent is undergoing orthodontic treatment. Termination will result in usual and customary charges for completion of treatment.
6. The following are not considered covered charges under this orthodontic plan:
  - Repair or replacement of lost or broken appliances.
  - Retreatment of orthodontic cases.
  - Changes in treatment necessitated by an accident.
  - Additional charges incurred due to patient neglect or non-compliance with prescribed course of treatment.
  - Maxillofacial surgery, orthognathic surgery, oral surgery for orthodontic purposes (including extractions), micrognathia, macroglossia, cleft palate, myofunctional therapy, speech therapy, treatment of TMJ.
  - X-rays and photographs required for the diagnostic workup.
  - Phase I orthodontic treatment (prior to full mouth banding).

\*Some Golden West orthodontic offices limit their practice to children. Please refer to your Golden West Network Directory for information on which offices accept adult cases.

**Any Procedure Not Listed is Available on a Fee for Service Basis.**

**This disclosure form is only a summary of the orthodontic and vision plans. The plan contract and evidence of coverage must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract and evidence of coverage is available on request for examination at the administrative office of Golden West Dental & Vision.**

## Golden West Dental & Vision    Uniform Matrix    89E Vision Plan

This benefit summary is intended to help you compare coverage, benefits, and limitations and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact Golden West. This comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available at [www.goldenwestdental.com](http://www.goldenwestdental.com). The Evidence of Coverage (EOC) should be consulted for a detailed description of benefits, limitations, exclusions, and the exact terms and conditions of your coverage. You have a right to review the EOC prior to enrollment. To obtain a copy of the EOC, please call (800) 995-4124. If you need further assistance, please contact the Department of Managed Health Care at (888) HMO-2219.

BENEFIT DESCRIPTION	COPAYMENTS	LIMITATIONS/EXCLUSIONS
<b>Annual Deductibles</b>	There is no annual deductible.	
<b>Calendar Year Maximums</b>	There are no calendar year maximums on treatment provided by a network vision provider.	
<b>Lifetime Maximums</b>	There are no lifetime maximums on treatment provided by a network vision provider.	
<b>Professional Services:</b>		
Visual Analysis	\$39	Medical Eye services excluded.
Contact Lens	\$40 - \$140 per lens	Minor fitting fee of \$30 is applicable in lieu of the complete fitting fee if the patient receives contact lens elsewhere.
Frames	25% discount	Not to be combined with any other offer.
Lens	25% discount	Not to be combined with any other offer.
Sunglasses	25% discount	Not to be combined with any other offer.
<b>Emergency Services*</b>	Not a covered benefit of this plan.	
<b>Outpatient Services*</b>	Not a covered benefit of this plan.	
<b>Hospitalization Services*</b>	Not a covered benefit of this plan.	
<b>Emergency Health Coverage*</b>	Not a covered benefit of this plan.	
<b>Ambulance Services*</b>	Not a covered benefit of this plan.	
<b>Prescription Drug Coverage*</b>	Not a covered benefit of this plan.	
<b>Durable Medical Equipment*</b>	Not a covered benefit of this plan.	
<b>Mental Health Services*</b>	Not a covered benefit of this plan.	
<b>Residential Treatment*</b>	Not a covered benefit of this plan.	
<b>Chemical Dependency Services*</b>	Not a covered benefit of this plan.	
<b>Home Health Services*</b>	Not a covered benefit of this plan.	
<b>Custodial Care and Skilled Nursing Facilities*</b>	Not a covered benefit of this plan.	

\*Golden West is required by regulation to provide this information. Golden West provides Dental, Orthodontic, and Vision benefits only.

## Golden West Dental & Vision    Uniform Matrix    Orthodontic Plan 4

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BENEFIT DESCRIPTION	COPAYMENTS	LIMITATIONS/EXCLUSIONS
<b>Annual Deductibles</b>	There is no annual deductible.	
<b>Calendar Year Maximums</b>	There are no calendar year maximums on treatment provided by a network orthodontist.	
<b>Lifetime Maximums</b>	There are no lifetime maximums on treatment provided by a network orthodontist.	
<b>Professional Services:</b>		
Diagnostic	\$0 - \$100	Payable only if patient does not proceed with treatment.
Treatment	\$1025- \$1795	Orthodontic care in excess of 24 months is member's responsibility.
Retainer Visits	\$100-\$200	Retainer visits and care for 6 months following completion of treatment period including cost of retainer visits.
Minor Tooth Movement	\$590	Orthodontic care in excess of 24 months is member's responsibility.
<b>Emergency Services*</b>	Not a covered benefit of this plan.	
<b>Outpatient Services*</b>	Not a covered benefit of this plan.	
<b>Hospitalization Services*</b>	Not a covered benefit of this plan.	
<b>Emergency Health Coverage*</b>	Not a covered benefit of this plan.	
<b>Ambulance Services*</b>	Not a covered benefit of this plan.	
<b>Prescription Drug Coverage*</b>	Not a covered benefit of this plan.	
<b>Durable Medical Equipment*</b>	Not a covered benefit of this plan.	
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