

89L3 DENTAL PLAN COPAYMENT SCHEDULE

Services as performed and deemed necessary for proper oral health by your Golden West Network General Dentist are subject to the following copayments.

| ADA CODE | PROCEDURE | MEMBER PAYS |
|------------------------------------|--|-------------|
| ORAL EXAMS | | |
| D0120 | Periodic oral evaluation | No Charge |
| D0140 | Limited oral evaluation | No Charge |
| D0150 | Comprehensive oral evaluation, new or established patient | No Charge |
| X-RAYS | | |
| D0210 | Intraoral, complete series, including bitewings | No Charge |
| D0220 | Intraoral, periapical, first film | No Charge |
| D0230 | Intraoral, periapical, each additional film | No Charge |
| D0240 | Intraoral, occlusal | No Charge |
| D0270/0272/0274 | Bitewing x-rays | No Charge |
| D0330 | Panoramic film | No Charge |
| CLEANINGS AND PREVENTIVE | | |
| D1110/1120 | Prophylaxis – adult or child | No Charge |
| D1201/1203 | Fluoride treatment, child | No Charge |
| D1204/1205 | Fluoride treatment, adult | 5 |
| D1330 | Oral hygiene instruction | No Charge |
| D1351 | Sealant, per tooth | 7 |
| SPACE MAINTAINERS* | | |
| D1510/1515 | Space maintainer, fixed | 30 |
| D1520/1525 | Space maintainer, removable | 40 |
| RESTORATIONS | | |
| D2140 | Amalgam, 1 surface, primary or permanent | No Charge |
| D2150 | Amalgam, 2 surfaces, primary or permanent | No Charge |
| D2160 | Amalgam, 3 surfaces, primary or permanent | No Charge |
| D2161 | Amalgam, 4 or more surfaces, primary or permanent | No Charge |
| D2330 | Resin, based composite, 1 surface, anterior | 8 |
| D2331 | Resin, based composite, 2 surfaces, anterior | 16 |
| D2332 | Resin, based composite, 3 surfaces, anterior | 24 |
| D2335 | Resin, based composite, 4 or more surfaces/incisal angle, anterior | 32 |
| CROWNS* | | |
| D2710 | Resin based composite, indirect | 50 |
| D2720/2721/2722 | Resin with metal | 60 |
| D2740 | Porcelain/ceramic substrate | 100 |
| D2750/2751/2752 | Porcelain fused to metal | 120 |
| D2750/2751/2752 | Porcelain fused to metal (molars) | 220 |
| D2780/2781/2782 | 3/4 cast metal | 100 |
| D2790/2791/2792 | Full cast metal | 100 |
| D2910 | Recement inlay, onlay or partial coverage restoration | No Charge |
| D2920 | Recement crown | No Charge |
| D2930 | Stainless steel, primary teeth | 10 |
| D2931 | Stainless steel, permanent teeth (to age 19) | 15 |
| D2940 | Sedative filling | No Charge |
| D2950 | Core build-up including pins | 20 |
| D2951 | Pin retention in addition to restoration, per tooth | 8 |
| D2952/2954 | Post and core in addition to crown | 20 |
| OTHER RESTORATIVE SERVICES* | | |
| D2960 | Labial veneer - resin laminate, chairside | 60 |

| ADA CODE | PROCEDURE | MEMBER PAYS |
|-----------------------------------|--|-------------|
| ENDODONTICS | | |
| D3110 | Pulp cap, direct, excluding final restoration | No Charge |
| D3120 | Pulp cap, indirect, excluding final restoration | No Charge |
| D3220 | Therapeutic pulpotomy, excluding final restoration | No Charge |
| D3221 | Pulpal debridement, primary or permanent teeth | 16 |
| D3310/3346 | Root canal therapy, anterior | 50 |
| D3320/3347 | Root canal therapy, bicuspid | 100 |
| D3330/3348 | Root canal therapy, molar | 150 |
| D3410 | Apicoectomy, anterior | 50 |
| D3421 | Apicoectomy, bicuspid, first root | 50 |
| D3425 | Apicoectomy, molar, first root | 50 |
| D3426 | Apicoectomy, each additional root | 20 |
| D3430 | Retrograde filling, per root | 60 |
| PERIODONTICS | | |
| D4210 | Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quad | 40 |
| D4211 | Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quad | 20 |
| D4260 | Osseous surgery, 4+ contiguous/bounded teeth, per quad | 100 |
| D4261 | Osseous surgery, 1-3 contiguous/bounded teeth, per quad | 50 |
| D4341 | Periodontal scaling and root planing, 4+ teeth, per quad | 20 |
| D4342 | Periodontal scaling and root planing, 1-3 teeth, per quad | 10 |
| D4355 | Full mouth debridement | 20 |
| D4381 | Localized delivery of antimicrobial agents, per tooth | 40 |
| PROSTHODONTICS, REMOVABLE* | | |
| D5110/5120 | Complete denture, upper or lower | 150 |
| D5211/5212 | Partial denture, resin base, upper or lower | 120 |
| D5213/5214 | Partial denture, cast metal framework, upper or lower | 175 |
| D5410/5411 | Adjust complete denture, upper or lower (first 2 visits) | No Charge |
| D5410/5411 | Adjust complete denture, upper or lower (subsequent visits) | 8 |
| D5421/5422 | Adjust partial denture, upper or lower (first 2 visits) | No Charge |
| D5421/5422 | Adjust partial denture, upper or lower (subsequent visits) | 8 |
| D5510 | Repair broken complete denture base | No Charge |
| D5520 | Replace missing or broken teeth, complete denture, per tooth | 5 |
| D5610 | Repair resin partial denture base | No Charge |
| D5620 | Repair cast framework | No Charge |
| D5630 | Repair or replace broken clasp | 5 |
| D5640 | Replace broken teeth, partial denture, per tooth | 5 |
| D5650/5660 | Add tooth or clasp to existing partial denture | 5 |
| D5730/5731 | Reline complete upper or lower denture, chairside | No Charge |
| D5740/5741 | Reline partial upper or lower denture, chairside | No Charge |
| D5750/5751 | Reline complete upper or lower denture, lab | 30 |
| D5760/5761 | Reline partial upper or lower denture, lab | 30 |
| D5820/5821 | Interim partial denture, upper or lower | 20 |
| D5850/5851 | Tissue conditioning, upper or lower | No Charge |
| PROSTHODONTICS, FIXED* | | |
| D6210/6211/6212 | Pontic, cast metal | 100 |
| D6240/6241/6242 | Pontic, porcelain fused to metal | 120 |
| D6545 | Retainer, cast metal for resin bonded fixed prosthesis | 70 |
| D6720/6721/6722 | Crown, resin with metal | 60 |
| D6750/6751/6752 | Crown, porcelain fused to metal | 120 |
| D6750/6751/6752 | Crown, porcelain fused to metal (molars) | 220 |
| D6790/6791/6792 | Crown, full cast metal | 100 |
| D6930 | Recement fixed partial denture | No Charge |
| D6940 | Stress breaker (per unit) | 10 |
| D6970/6972 | Post and core in addition to fixed partial denture retainer | 20 |
| D6973 | Core buildup for retainer, including pins | 20 |
| ORAL SURGERY | | |
| D7140 | Extraction, erupted tooth or exposed root | No Charge |
| D7210 | Surgical removal of erupted tooth | 15 |
| D7220 | Removal of impacted tooth, soft tissue | 20 |
| D7230 | Removal of impacted tooth, partially bony | 30 |
| D7240 | Removal of impacted tooth, completely bony | 50 |
| D7310 | Alveoloplasty with extractions, per quadrant | 50 |
| D7311 | Alveoloplasty with extractions, 1-3 teeth, per quadrant | 25 |
| D7320 | Alveoloplasty, without extractions, per quadrant | 50 |
| D7321 | Alveoloplasty, without extractions, 1-3 teeth, per quadrant | 25 |

| ADA CODE | PROCEDURE | MEMBER PAYS |
|----------|---|-------------|
| | ORAL SURGERY (Cont.) | |
| D7471 | Removal of lateral exostosis | No Charge |
| D7960 | Frenulectomy, separate procedure | No Charge |
| D7970 | Excision of hyperplastic tissue, per arch | 25 |
| | ADJUNCTIVE GENERAL SERVICES | |
| D9110 | Palliative treatment, emergency | No Charge |
| D9215 | Local anesthesia | No Charge |
| D9430 | Office visit for observation, regular office hours, no other services performed | No Charge |
| D9440 | Office visit after regularly scheduled hours | 25 |
| | MISSED APPOINTMENTS | |
| | Without 24 hours prior notice | 20 |

*Base metal is the benefit. Noble and high noble metal (gold), if used, will be charged to the member at the additional laboratory cost of the noble or high noble metal. This applies to crowns, bridges, cast posts and cores. Copayments do not include charge for dental laboratory fees.

SEE PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS

All services as performed by a Golden West Network General Dentist. Any procedure not listed and provided by the general dentist is available on a fee for service basis. Some procedures may be available in selected offices only. Copayment is due at time services are rendered. Out of area emergency reimbursement is limited to \$50.00 per calendar year.

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. 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 |
|---|---|--|
| Annual Deductibles | There is no annual deductible. | |
| Calendar Year Maximums | There are no calendar year maximums on treatment provided by a network general dentist. | |
| Lifetime Maximums | There are no lifetime maximums on treatment provided by a network general dentist. | |
| Professional Services: | | |
| Oral exams | \$0 | Once every six (6) months. |
| Prophylaxis (cleaning) | \$0 | Once every six (6) months. |
| Bitewing x-rays | \$0 | One series of films in twelve (12) months. |
| Full mouth x-rays | \$0 | Once every three (3) years. |
| Fluoride (child) | \$0 | Once every twelve (12) months. |
| Sealants | \$7 per tooth | Allowed in permanent first and second molars to age 16. |
| Amalgam fillings (primary or permanent teeth) | \$0 | Treatment of rampant caries is limited to the first seven (7) most severely decayed primary teeth. |
| Resin fillings, anterior (front) teeth | \$8-\$32 | Treatment of rampant caries is limited to the first seven (7) most severely decayed primary teeth. |
| Crowns, single restoration | \$50-\$220 + lab fee | Must be more than five (5) years old for replacement coverage. Covered only when tooth cannot be restored with an intracoronal restoration, unless tooth is diagnosed as having cracked tooth syndrome. Base metal is the benefit. Member will be responsible for additional cost of noble and high noble metal. |
| Root Canal Therapy | \$50-\$150 | Teeth with poor prognosis are not covered for endodontic treatment. |
| Apicoectomy (first root) | \$50 | Teeth with poor prognosis are not covered for endodontic treatment. |
| Osseous surgery | \$50-\$100 | Limited to four (4) quadrants per lifetime. |
| Scaling and Root Planing | \$10-\$20 | Limited to four (4) quadrants per calendar year. |
| Full Mouth Dentures | \$150 + lab fee | Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered. |
| Partial Dentures | \$120-\$175 + lab fee | Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered. |
| Fixed bridge | \$60-\$220 per unit + lab fee | A fixed bridge in any posterior quadrant is considered elective when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. In this case, a partial denture would be covered. |
| Extraction of erupted tooth | \$0-\$15 | Extractions for orthodontic purposes are not covered. |
| Removal of impacted tooth | \$20-\$50 | Extractions for orthodontic purposes are not covered including the extraction of non-pathologic, asymptomatic teeth. |
| Emergency palliative treatment | \$0 | None |
| Outpatient Services* | | |
| | | Not a covered benefit of this plan. |
| Hospitalization Services* | | |
| | | Not a covered benefit of this plan. |
| Emergency Health Coverage* | | |
| | | Not a covered benefit of this plan. |
| Ambulance Services* | | |
| | | Not a covered benefit of this plan. |
| Prescription Drug Coverage* | | |
| | | Not a covered benefit of this plan. |
| Durable Medical Equipment* | | |
| | | Not a covered benefit of this plan. |
| Mental Health Services* | | |
| | | Not a covered benefit of this plan. |
| Residential Treatment* | | |
| | | Not a covered benefit of this plan. |
| Chemical Dependency Services* | | |
| | | Not a covered benefit of this plan. |
| Home Health Services* | | |
| | | Not a covered benefit of this plan. |
| Custodial Care and Skilled Nursing Facilities* | | |
| | | 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.