GOLDEN WEST DENTAL & VISION

Exhibit A

PREFERRED CHOICE

PREFERRED CHOICE 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	7
D1330	Oral hygiene instruction	No Charge
D1351	Sealant, per tooth	11
	SPACE MAINTAINERS*	
D1510/1515	Space maintainer, fixed	60
D1520/1525	Space maintainer, removable	65
D1550	Recement space maintainer	No Charge
	RESTORATIONS	
D2140	Amalgam, 1 surface, primary	10
D2150	Amalgam, 2 surfaces, primary	14
D2160	Amalgam, 3 surfaces, primary	18
D2161	Amalgam, 4 or more surfaces, primary	28
D2140	Amalgam, 1 surface, permanent	12
D2150	Amalgam, 2 surfaces, permanent	16
D2160	Amalgam, 3 surfaces, permanent	20
D2161	Amalgam, 4 or more surfaces, permanent	30
D2330	Resin based composite, 1 surface, anterior	16
D2331	Resin based composite, 2 surfaces, anterior	28
D2332	Resin based composite, 3 surfaces, anterior	40
D2335	Resin based composite, 4 or more surfaces/incisal angle, anterior	52
	CROWNS*	
D2720/2721/2722	Resin with metal	100
D2720/2721/2722	Resin with metal (molars)	200
D2740	Porcelain/ceramic substrate	150
D2750/2751/2752	Porcelain fused to metal	175
D2750/2751/2752	Porcelain fused to metal (molars)	275
D2780/2781/2782	3/4 cast metal	150
D2790/2791/2792	Full cast metal	150
D2910	Recement inlay, onlay or partial coverage restoration	15
D2920	Recement crown	15
D2930	Stainless steel, primary teeth	40
D2940	Sedative filling	No Charge
D2950	Core build-up including pins	40
D2951	Pin retention in addition to restoration, per tooth	15
D2952/2954	Post and core in addition to crown	50
	OTHER RESTORATIVE*	
D2960	Labial veneer - resin laminate, chairside, per tooth	100
	ENDODONTICS	
D3110/3120	Pulp cap, direct or indirect, excluding final restoration	5
D3220	Therapeutic pulpotomy, excluding final restoration	20
D3310/3346	Root canal therapy, anterior	100
D3320/3347	Root canal therapy, bicuspid	150
D3330/3348	Root canal therapy, molar	220

ADA CODE	PROCEDURE	MEMBER PAYS
D3410	Apicoectomy, anterior	95
D3421	Apicoectomy, bicuspid, first root	95
D3425	Apicoectomy, molar, first root	95
D3426	Apicoectomy, each additional root	45
D3430	Retrograde filling, per root	75
	PERIODONTICS	
D4210	Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quad	95
D4211	Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quad	48
D4260	Osseous surgery, 4+ contiguous/bounded teeth, per quad	220
D4261	Osseous surgery, 1-3 contiguous/bounded teeth, per quad	110
D4341	Periodontal scaling and root planing, 4+ teeth, per quad	45
D4342	Periodontal scaling and root planing, 1-3 teeth, per quad	23
D4355	Full mouth debridement	35
D4910	Perio maintenance	30
	PROSTHODONTICS, REMOVABLE*	
D5110/5130	Complete or immediate upper denture	195
D5120/5140	Complete or immediate lower denture	195
D5211/5212	Partial denture, resin base, upper or lower	165
D5213/5214	Partial denture, cast metal framework, upper or lower	225
D5410/5411/5421/5422	Adjust complete or partial denture, upper or lower	No Charge
D5510	Repair broken complete denture base	30
D5520	Replace missing or broken teeth, complete denture, per tooth	25
D5610	Repair resin partial denture base	30
D5620	Repair cast framework	40
D5630	Repair or replace broken clasp	15
D5640	Replace broken teeth, partial denture, per tooth	25
D5650/5660	Add tooth or clasp to existing partial denture	40
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	65
D5760/5761	Reline partial upper or lower denture, lab	65
D5820/5821	Interim partial denture, upper or lower	70
D5850/5851	Tissue conditioning, upper or lower	No Charge
	PROSTHODONTICS, FIXED*	
D6210/6211/6212	Pontic, cast metal	150
D6240/6241/6242	Pontic, porcelain fused to metal	175
D6240/6241/6242	Pontic, porcelain fused to metal (molars)	275
D6720/6721/6722	Crown, resin with metal	100
D6720/6721/6722	Crown, resin with metal (molars)	200
D6750/6751/6752	Crown, porcelain fused to metal	175
D6750/6751/6752	Crown, porcelain fused to metal (molars)	275
D6780/6781/6782	Crown, 3/4 cast metal	150
D6790/6791/6792	Crown, full cast metal	150
D6930	Recement fixed partial denture	15
D6970/6972	Post and core in addition to fixed partial denture retainer	50
D6971	Cast post and core as part of fixed partial denture retainer	50
D6973	Core buildup for retainer, including pins	40
	ORAL SURGERY	
D7140	Extraction, erupted tooth or exposed root	15
D7210	Surgical removal of erupted tooth	35
D7220	Removal of impacted tooth, soft tissue	50
D7230	Removal of impacted tooth, partially bony	85
D7240	Removal of impacted tooth, completely bony	105
D7510	Incision and drainage of abscess – intraoral soft tissue	25
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative treatment, emergency	15
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	35
	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.

Golden West Dental & Vision Uniform Matrix Preferred Choice 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. 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 treatment	$0-$7	Once every twelve (12) months.
Sealants	$11 per tooth	Allowed in permanent first and second molars to age 16.
Amalgam fillings (primary or permanent teeth)	$10-$30	Treatment of rampant caries is limited to the first seven (7) most severely decayed primary teeth.
Resin fillings, anterior (front) teeth	$16-$52	Treatment of rampant caries is limited to the first seven (7) most severely decayed primary teeth.
Crowns, single restoration	$100-$275 + 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	$100-$220	Teeth with poor prognosis are not covered for endodontic treatment.
Apicoectomy (first root)	$95	Teeth with poor prognosis are not covered for endodontic treatment.
Osseous surgery	$110-$220	Limited to four (4) quadrants per lifetime.
Scaling and Root Planing	$23-$45	Limited to four (4) quadrants per calendar year.
Full Mouth Dentures (either complete or immediate)	$195 + lab fee	Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered.
Partial Dentures	$165-$225 + lab fee	Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered.
Fixed bridge	$100-$275 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 purposed of supporting a pontic. In this case, a partial denture would be covered.
Extraction of erupted tooth	$15-$35	Extractions for orthodontic purposes are not covered.
Removal of impacted tooth	$50-$105	Extractions for orthodontic purposes are not covered including the extraction of non-pathologic, asymptomatic teeth.
Emergency palliative treatment	$15	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.