



This Disclosure Booklet is only a summary of the Dental Plan. The Plan Contract and Evidence of Coverage must be consulted to determine the exact terms, limitations and exclusions of coverage. The enrollee has a right to review a specimen copy of the contract prior to enrollment. A specimen copy of the contract is available at the administrative office of SmileChoice/Golden West Dental & Vision.

### ***Continuity of Care***

In the event of termination of this agreement or the agreement with the network dentist, the dentist shall complete all procedures started prior to the termination under the terms of this contract. For example: If a final impression has been taken, dentist will complete the crown, bridge or denture for copayment (plus lab fee where applicable). If assistance is required, member may request such assistance from Plan by calling (800) 995-4124. This continuity of care shall be provided for a term not to exceed 90 days.

If you have any questions or need additional assistance, please contact SmileChoice/Golden West Dental & Vision at (800) 995-4124.

The SmileChoice Dental Plan benefits are located on this brochure. The Uniform Matrix for this plan is an insert included with this disclosure booklet. The Plan Contract and Evidence of Coverage should be read completely and carefully and individuals with special health care needs should read carefully those sections that apply to them.

### ***Binding Arbitration***

In the event of any controversy or dispute between interested parties (which term includes the Subscriber, a Member or Dependent, and the Plan, Agents, Plan Providers, or employees) including disputes which are not adequately resolved by the Plan's grievance procedures, shall be submitted to binding arbitration. Such arbitration may be initiated by either party, but if the matter in dispute is one which is subject to review under the Plan's grievance procedures, arbitration may not be initiated until the completion of such procedures.

The arbitration process may be initiated by calling the American Arbitration Association at (213) 383-6516 and requesting a Demand for Arbitration.

The Arbitrator shall determine which party shall bear the cost of arbitration, including reasonable attorney's fees. The Subscriber, Dependent, or Member and the Plan will follow applicable law with regard to arbitration. California law may require, for a dispute involving \$200,000 or less, that the Subscriber, Dependent, or Member and the Plan select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than \$200,000.

## **— Welcome to SmileChoice™ !**

### ***• Your savings are unlimited***

SmileChoice/Golden West Dental & Vision has been in business since 1974! You are joining a dental plan that brings you exceptional service and savings on dental and vision care for Students, Graduates, Alumni and their eligible dependents.

### ***Guaranteed acceptance!***

#### ***• No charge for x-rays***

You save \$105 per person every year!

#### ***• No charge for dental exams***

Regular checkups can help prevent future problems.

#### ***• Low-cost routine teeth cleaning***

Now it's affordable to have your teeth cleaned twice each year as recommended by dentists!

#### ***• Big savings on dental services***

You'll realize instant savings on everything from fillings to crowns.

#### ***• Cosmetic services covered***

Cosmetic crowns, laminates and even bleaching are all covered!

#### ***• Choose your personal dentist and vision care provider***

There are hundreds of private, pre-screened dentists and vision care providers to choose from, conveniently located throughout California.

#### ***• Easy to use***

Just show your personal SmileChoice membership card for automatic savings.

#### ***• No deductible***

#### ***• No claim forms to fill out***

#### ***• 24-hour emergency service***

A SmileChoice member service representative is available 24 hours each day, because you never know when emergencies will happen.

#### ***• Orthodontic services are covered***

SmileChoice can save you and your family hundreds of dollars.

#### ***• Your savings are unlimited***

There are no annual maximum benefit limitations on the SmileChoice plan!

### ***Your Satisfaction is 100% guaranteed***

You'll save money with your SmileChoice membership and you have this Complete Guarantee of Satisfaction:

If you're not satisfied with your SmileChoice Plan at any time, for any reason, you may cancel and receive a full refund of your unused membership fees.

## **DEFINITIONS**

**SUBSCRIBER** - Individual in whose name family unit is enrolled.

**MEMBER** - Any individual subscriber or eligible family dependent entitled to receive services under this Agreement.

**DEPENDENT** - Lawful spouse of Subscriber and/or unmarried children to age 19. All unmarried children 19 years or older but less than 23 years old who are full-time students. Coverage will continue beyond the age limitations for dependents who are chiefly dependent upon the Subscriber for support due to retardation or physical handicap. Proof of such continuing dependency must be furnished to Plan upon request.

**BENEFITS** - Services provided under this Agreement. Also referred to as Coverage.

**COPAYMENT** - Additional fees required under this Agreement for specific services. These fees are paid by Member directly to Provider.

**PROVIDER** - A licensed professional who provides services for the Member and with whom the Plan has contracted. Used interchangeably with Facility.

**NON-PANEL PROVIDER** - A licensed professional not under contract with Plan. Service with a non-panel Provider must be authorized in writing by the Plan.

**SERVICE AREA** - Geographic areas within a 30 mile radius from any Plan Provider/Facility.

**CAUSE OR GOOD CAUSE** - Nonpayment of premiums due, fraud or deception by Subscriber, Member or Group or permitting such fraud or deception by another. Breach of any term or condition of this Agreement.

**THERAPEUTIC** - Treatment of disease.

**TREATMENT IN PROGRESS** - Beginning of an irreversible procedure (i.e. tooth prepared for crown/ tooth opened for root canal therapy).

### **General Exclusions and Limitations on Benefits**

1. Treatment must be received from the Member's participating dental or vision care provider unless exception is specifically authorized, in writing, by the Plan.
2. Any procedure not specifically listed as a covered benefit is excluded.
3. Treatment or expenses incurred or in connection with any procedures started prior to the Member's effective date under this Plan or after termination of the Member's coverage are excluded. Example: teeth prepared for crowns, root canal treatment in progress.

#### **• Dental Exclusions and Limitations on Benefits**

1. Prophylaxis procedures are limited to once every six (6) months.
2. General anesthesia, inhalation sedation, intravenous sedation, or intramuscular sedation.
3. Replacement of lost or stolen dentures, crown and bridge work, or other dental appliances.
4. Treatment of Temporomandibular Joint (TMJ) disturbances, hormonal imbalances, cleft palate, micronathia, macroglossia, and myofunctional therapies are excluded services.

#### **• Orthodontic Exclusions and Limitations**

1. Limited to children under 19 years of age, except where adult cases are accepted as indicated on the provider directory.
2. Treatment copayments are for 24 months of treatment. Treatment in excess of 24 months (extended treatment) is available at usual, customary and reasonable (UCR) fees, payable until treatment is completed (retainers are placed).
3. Subscriber and his or her eligible dependent must remain on the Plan during the period of time the subscriber or his or her eligible dependent is under- going orthodontic treatment. An early termination will result in usual and customary charges for all unfinished work.
4. Orthodontic treatment must be provided by a member of the SmileChoice orthodontic panel.
5. The following are not benefits included as orthodontia:
  - a. X-rays for orthodontic purposes
  - b. Tracings and photographs
  - c. Phase 1 orthodontic treatment (prior to full mouth banding)
6. Treatment in progress started prior to a Member's eligibility under this Plan.
7. Surgical procedures for orthodontic treatment.
8. Severe or mutilated malocclusions.
9. Retreatment of orthodontic cases.
10. Changes in treatment necessitated by accident of any kind.

#### **• Vision Exclusions and Limitations**

1. Follow-up care for contact lenses shall be limited to a period of three (3) months after the contact lens evaluation. Additional visits are subject to an office visit charge which is set by the doctor's UCR fee.
2. Medical or surgical treatment of the eyes or any procedure requiring an Ophthalmologist or any hospital or medical charges. In the event that Member desires to be hospitalized for any ocular procedure, the cost will be borne by the Member.

#### **• Other Charges**

The Member is responsible for the copayments for services listed in the "Principal Benefits and Coverages Copayment Schedule." Services not listed will be billed to the Member at the dentist's UCR fee.

- ***Choice of Dentists, Orthodontists & Vision Care Provider***

Each subscriber and eligible dependent must select a participating dentist, orthodontist and vision care provider from the current list of participating dental and vision care offices, or from our website at [www.smilechoice.com](http://www.smilechoice.com). Select a maximum of three (3) dental, ortho and vision office locations per family (one (1) doctor per member, three (3) per family.)

- ***Liability of Subscriber or Enrollee for Payment***

In the event the Plan fails to pay the participating provider, the provider will not look to the Member for payment. The Member will not be liable. If the Plan fails to pay a non-participating provider, the Member may be liable to such provider for the cost of services received by that Member.

- ***Reimbursement Provisions***

Plan Members can be reimbursed up to \$50.00 annually for emergency dental services while more than 30 miles away from the Member's participating Dental Plan Provider, or \$20.00 annually for emergency vision services while more than 30 miles away from the Member's participating Vision Plan Provider. Proof of receipt of such services must be submitted to the Plan in writing.

- ***Facilities***

Participating Providers are available for non-emergency care during their regular office hours. Emergency care is available on a 24-hour basis. Names and locations of the Plan's participating offices are located on the list of participating dental and vision care offices, as well as on our website at [www.smilechoice.com](http://www.smilechoice.com).

- ***Termination of Benefits/Disenrollment***

After the date on which termination becomes effective, the Participating Provider will complete any "service in progress" as defined in the Plan's Subscriber Contract and Evidence of Coverage. Benefits shall cease upon (a) the date coverage expires if not renewed; (b) notice that a satisfactory Provider-patient relationship cannot be established; (c) upon a dependent attaining age 19 (or 23 if full-time student) or upon a dependent's marriage.

- ***Grievance Procedure***

Direct all grievances to the Plan. Unresolved grievances will be settled by arbitration.

### SMILECHOICE PLAN 100 (SC100) 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. Please contact the Plan at (800) 995-4124 for a referral to a participating specialist.

ADA CODE	PROCEDURE	MEMBER PAYS
<b>ORAL EXAMS</b>		
D0120	Periodic oral evaluation	No Charge
D0140	Limited oral evaluation	No Charge
D0150	Comprehensive oral evaluation, new or established patient	No Charge
D0460	Pulp vitality tests	No Charge
<b>X-RAYS</b>		
D0210	Intraoral, complete series, including bitewings (not including orthodontic x-rays)	No Charge
D0220	Intraoral, periapical, first film	No Charge
D0230	Intraoral, periapical, each additional film	No Charge
D0240	Intraoral, occlusal film	No Charge
D0270/0272/0274	Bitewing x-rays	No Charge
D0330	Panoramic film	No Charge
<b>CLEANINGS AND PREVENTIVE</b>		
D1110	Prophylaxis – adult	20
D1120	Prophylaxis – child	20
D1201	Topical application of fluoride treatment, including prophy - child	25
D1203	Topical application of fluoride treatment, prophy not included - child	5
D1204	Topical application of fluoride treatment, prophy not included - adult	5
D1330	Oral hygiene instruction	No Charge
D1351	Sealant, per tooth	10
<b>SPACE MAINTAINERS</b>		
D1510	Space maintainer, fixed - unilateral	95
D1515	Space maintainer, fixed - bilateral	135
D1520	Space maintainer, removable - unilateral	115
D1525	Space maintainer, removable - bilateral	145
D1550	Recement space maintainer	22
<b>RESTORATIONS</b>		
D2140	Amalgam, 1 surface (primary)	30
D2150	Amalgam, 2 surfaces (primary)	38
D2160	Amalgam, 3 surfaces (primary)	47
D2161	Amalgam, 4 or more surfaces (primary)	56
D2140	Amalgam, 1 surface (permanent)	33
D2150	Amalgam, 2 surfaces (permanent)	44
D2160	Amalgam, 3 surfaces (permanent)	51
D2161	Amalgam, 4 or more surfaces (permanent)	64
D2330	Resin based composite, 1 surface, anterior	46
D2331	Resin based composite, 2 surfaces, anterior	57
D2332	Resin based composite, 3 surfaces, anterior	72
D2335	Resin based composite, 4 or more surfaces/incisal angle, anterior	89
D2940	Sedative filling	28
<b>CROWNS</b>		
D2751	Porcelain fused to predominantly base metal	380
D2781	3/4 cast predominantly base metal	370
D2791	Full cast predominantly base metal	340
D2910	Recement inlay, onlay or partial coverage restoration	27
D2920	Recement crown	28
D2930	Prefabricated stainless steel crown, primary	75
D2931	Prefabricated stainless steel crown, permanent	85
D2950	Core build-up including pins & posts	75
D2951	Pin retention in addition to restoration, per tooth	15
D2952	Cast post and core in addition to crown	120
D2954	Prefabricated post and core in addition to crown	90

ADA CODE	PROCEDURE	MEMBER PAYS
<b>ENDODONTICS</b>		
D3110	Pulp cap, direct, excluding final restoration	22
D3120	Pulp cap, indirect, excluding final restoration	21
D3220	Therapeutic pulpotomy, excluding final restoration	50
D3310	Root canal therapy, anterior	215
D3320	Root canal therapy, bicuspid	255
D3330	Root canal therapy, molar	320
D3351	Apexification/recalcification - initial visit	98
D3352	Apexification/recalcification - interim visit	67
D3353	Apexification/recalcification - final visit	115
D3410	Apicoectomy, anterior	180
D3421	Apicoectomy, bicuspid, first root	202
D3425	Apicoectomy, molar, first root	230
D3426	Apicoectomy, each additional root	88
D3430	Retrograde filling, per root	70
<b>PERIODONTICS</b>		
D4210	Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quad	195
D4211	Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quad	65
D4260	Osseous surgery, 4+ contiguous/bounded teeth, per quad	340
D4261	Osseous surgery, 1-3 contiguous/bounded teeth, per quad	170
D4341	Periodontal scaling and root planing, 4+ teeth, per quad	75
D4342	Periodontal scaling and root planing, 1-3 teeth, per quad	38
D4355	Full mouth debridement	50
D4381	Localized delivery of antimicrobial agent, per tooth	38
D4910	Perio maintenance (following active therapy)	42
D4999	Initial perio charting for moderate or advanced cases	5
<b>PROSTHODONTICS, REMOVABLE</b>		
D5110/5120	Complete upper or lower denture	440
D5130/5140	Immediate upper or lower denture	490
D5211/5212	Partial denture, resin base, upper or lower	340
D5213/5214	Partial denture, cast metal framework, upper or lower	470
D5410/5411	Adjust complete denture, upper or lower	22
D5421/5422	Adjust partial denture, upper or lower	22
D5820/5821	Interim partial denture, upper or lower	180
D5510	Repair broken complete denture base	50
D5520	Replace missing or broken teeth, complete denture, per tooth	48
D5610	Repair resin denture base	50
D5620	Repair cast framework	75
D5630	Repair or replace broken clasp	70
D5640	Replace broken teeth, per tooth	48
D5650	Add tooth to existing partial denture	63
D5660	Add clasp to existing partial denture	75
D5710/5711	Rebase complete upper or lower denture	165
D5720/5721	Rebase upper or lower partial	155
D5730/5731	Reline complete upper or lower denture, chairside	100
D5740/5741	Reline partial upper or lower denture, chairside	98
D5750/5751	Reline complete upper or lower denture, lab	135
D5760/5761	Reline partial upper or lower denture, lab	135
D5850/5851	Tissue conditioning, upper or lower	48
<b>PROSTHODONTICS, FIXED</b>		
D6211	Pontic, cast predominantly base metal	345
D6241	Pontic, porcelain fused to predominantly base metal	390
D6751	Crown, porcelain fused to predominantly base metal	390
D6791	Crown, full cast predominantly base metal	345
D6930	Recement fixed partial denture	43
D6970	Cast post and core in addition to fixed partial denture retainer	125
D6971	Cast post as part of a fixed partial denture retainer	112
D6972	Prefabricated post and core in addition to fixed partial denture retainer	95
D6973	Core buildup for retainer, including pins	75

ADA CODE	PROCEDURE	MEMBER PAYS
<b>ORAL SURGERY</b>		
D7140	Extraction, erupted tooth or exposed root	40
D7210	Surgical removal of erupted tooth	75
D7220	Removal of impacted tooth, soft tissue	85
D7230	Removal of impacted tooth, partially bony	120
D7240	Removal of impacted tooth, completely bony	155
D7250	Removal of residual tooth roots	80
D7960	Frenulectomy	120
<b>ADJUNCTIVE GENERAL SERVICES</b>		
D9110	Palliative treatment, emergency	33
D9215	Local anesthesia	No Charge
D9430	Office visit for observation, regular office hours, no services rendered	No Charge
D9440	Office visit after regularly scheduled hours	48
D9930	Treatment of post-surgical complications	No Charge
<b>MISCELLANEOUS SERVICES</b>		
D9941	Occlusal guard, athletic	130
D9951	Occlusal adjustment, limited	33
D0470	Diagnostic casts	30
<b>MINOR TREATMENT TO CONTROL HARMFUL HABITS</b>		
D8210	Removable appliance therapy	230
D8220	Fixed appliance therapy	270
D8999	Office visit for observation, adjustment or activation, per visit	22
<b>ELECTIVE SERVICES</b>		
<b>Resin Restorations-posterior permanent teeth</b>		
D2391	Resin based composite – 1 surface	60
D2392	Resin based composite – 2 surface	80
D2393	Resin based composite – 3 surface	100
D2394	Resin based composite – 4 or more surfaces	120
<b>Other Elective Procedures</b>		
D2751	Cosmetic crown, porcelain fused to predominantly base metal	380
D2962	Labial veneers, porcelain laminate	370
D6241	Pontic, porcelain fused to predominantly base metal	390
D6751	Crown, porcelain fused to predominantly base metal	390
D9972	External bleaching, per arch	170
<b>FAILED APPOINTMENTS</b>		
	Failure to cancel appointment (24 hours prior notice)	20
<b>RECORD TRANSFER</b>		
	Transfer of all materials with less than a full mouth x-ray	10
	Transfer of all materials with a full mouth x-ray	21

**Note A:** Cost of noble or high noble metal (gold, etc.) may be charged extra when used, not to exceed actual laboratory cost of metal.

**Note B:** Copayments listed are for services performed by a participating general dentist. Copayments for services performed by a participating dental specialist are listed in the subscriber contract.

**SEE PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS**

Any procedures not listed and provided by the general dentist are available on a fee for service basis. 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      SmileChoice 100 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 general dentist.	
<b>Lifetime Maximums</b>	There are no lifetime maximums on treatment provided by a network general dentist.	
<b>Professional Services:</b>		
Oral exams	\$0	Once every six (6) months.
Prophylaxis (cleaning)	\$20	Once every six (6) months.
Bitewing x-rays	\$0	One series of films in twelve (12) months.
Full mouth x-rays	\$0-\$48	Once every three (3) years.
Fluoride	\$5	Once every twelve (12) months.
Sealants	\$10 per tooth	None
Amalgam fillings (primary or permanent teeth)	\$30-\$64	None
Resin fillings, anterior (front) teeth	\$46-\$89	None
Crowns, single restoration	\$340-\$390	Must be more than five (5) years old for replacement coverage.
Root Canal Therapy	\$215-\$320	Teeth with poor prognosis are not covered for endodontic treatment. Retreatment of previous endodontic therapy is not covered.
Apicoectomy (first root)	\$180-\$230	Teeth with poor prognosis are not covered for endodontic treatment.
Osseous surgery	\$170-\$340	None
Scaling and Root Planing	\$38-\$75	Limited to one course of therapy in a 12 month period.
Full Mouth Dentures	\$440-\$490	Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered.
Partial Dentures	\$340-\$470	Partial dentures are not eligible for replacement within (3) years of original placement unless required as a result of tooth loss, which cannot be restored by modification of the existing partial.
Fixed bridge	\$345-\$390 per unit	Must be more than five (5) years old for replacement coverage.
Extraction of erupted tooth	\$40-\$75	All treatment of fractures and dislocations are excluded. Extractions for orthodontic purposes are not covered.
Removal of impacted tooth	\$85-\$155	All treatment of fractures and dislocations are excluded. Extractions for orthodontic purposes are not covered.
Emergency palliative treatment	\$33	None
<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.

## 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 (eye exam, including glaucoma testing)	\$ 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*		

\*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.

### 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.

## 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

\*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.**

### 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).

**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.**

## SmileChoice Plan 100 & 200 Plan G – Specialist Addendum

Services must be performed by a Plan Specialist.  
Please contact the PLAN at (800) 995-4124 for a referral to a participating specialist.

ADA Code	Procedure	Member's Co-Pay
	<b>DIAGNOSTIC</b>	
D0210	Intraoral, complete series (including bitewings)	\$48.00
D0220	Intraoral, periapical first film	\$16.00
D0230	Intraoral, periapical each additional radiograph	\$8.00
D0330	Panoramic film	\$33.00
D9310	Consultation, exam at Plan specialist	\$50.00
	<b>ORAL SURGERY</b>	
D7140	Extraction, erupted tooth or exposed root including post operative visits	\$60.00
D7210	Surgical removal of erupted teeth including postoperative care	\$90.00
D7220	Removal of impacted tooth-soft tissue	\$130.00
D7230	Removal of impacted tooth-partially bony	\$160.00
D7240	Removal of impacted tooth-completely bony	\$190.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	75% UCR
D7510	Incision and drainage of abscess, intraoral soft tissue	75% UCR
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	75% UCR
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	75% UCR
D7910	Suture of small wounds up to 5 cm	75% UCR
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	75% UCR
D7970	Excision of hyperplastic tissue per arch	75% UCR
D9930	Postoperative visits, complications	\$17.00
	<b>PERIODONTICS</b>	
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	75% UCR
D4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant	75% UCR
D4260	Osseous surgery, including flap entry and closure, four or more contiguous teeth or bounded teeth spaces per quadrant	75% UCR
D4261	Osseous surgery, including flap entry and closure, one to three contiguous teeth or bounded teeth spaces per quadrant	75% UCR
D4341	Periodontal scaling and root planing, four or more teeth spaces per quadrant	\$130.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	\$75.00
D4910	Periodontal maintenance procedure following active therapy	75% UCR
D9110	Palliative (emergency) treatment of dental pain, minor procedures	\$50.00
D9951	Occlusal adjustment, limited	75% UCR
	<b>ENDODONTICS</b>	
D3310	Root canal therapy, anterior	75% UCR
D3320	Root canal therapy, bicuspid	75% UCR
D3330	Root canal therapy, molar	75% UCR
D3351	Apexification/recalcification, initial visit	75% UCR
D3352	Apexification/recalcification, interim visit	75% UCR
D3353	Apexification/recalcification, final visit	75% UCR
D3410	Apicoectomy/periradicular surgery	75% UCR
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	75% UCR
D3425	Apicoectomy/periradicular surgery, molar (first root)	75% UCR
D3426	Apicoectomy/periradicular surgery, each additional root	75% UCR
D3430	Retrograde filling, per root	75% UCR
D3450	Root amputation, per root	75% UCR
D3920	Hemisection (including any root removal)	75% UCR
	Missed appointment with out prior notice	\$22.00

"UCR" means "usual, customary and reasonable" fees. These are the fees that are regularly charged to private non-insured patients in a specific geographic area. There may be an additional payment over and above the Specialist's usual fee if there are unusual circumstances, and it is reasonable for the Specialist to allow more than the usual charge.