GOLDEN WEST
DENTAL & VISION

Exhibit A

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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.

Golden West Dental & Vision Uniform Matrix 89L3 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. Please refer to the back of your ID card and call the number to request a copy of the EOC. 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 purposed 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.