GOLDEN WEST DENTAL & VISION

Exhibit A

S C 2 0 0

SMILECHOICE PLAN 200 (SC200)
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 refer to the back of your ID card and call the number for a referral to a participating specialist.

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
D0460	Pulp vitality tests	No Charge
	X-RAYS	
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
	CLEANINGS AND PREVENTIVE	
D1110	Prophylaxis – adult	No Charge
D1120	Prophylaxis – child	No Charge
D1201	Topical application of fluoride treatment, including prophy - child	5
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
	SPACE MAINTAINERS	
D1510	Space maintainer, fixed - unilateral	35
D1515	Space maintainer, fixed - bilateral	75
D1520	Space maintainer, removable - unilateral	35
D1525	Space maintainer, removable - bilateral	85
D1550	Recement space maintainer	8
	RESTORATIONS	
D2140	Amalgam, 1 surface (primary)	6
D2150	Amalgam, 2 surfaces (primary)	11
D2160	Amalgam, 3 surfaces (primary)	13
D2161	Amalgam, 4 or more surfaces (primary)	19
D2140	Amalgam, 1 surface (permanent)	8
D2150	Amalgam, 2 surfaces (permanent)	13
D2160	Amalgam, 3 surfaces (permanent)	21
D2161	Amalgam, 4 or more surfaces (permanent)	24
D2330	Resin based composite, 1 surface, anterior	18
D2331	Resin based composite, 2 surfaces, anterior	24
D2332	Resin based composite, 3 surfaces, anterior	28
D2335	Resin based composite, 4 or more surfaces/incisal angle, anterior	34
D2940	Sedative filling	No Charge
	CROWNS	
D2751	Crown, porcelain fused to predominantly base metal, anterior	170*
D2751	Crown, porcelain fused to predominantly base metal, posterior	350*
D2781	Crown, 3/4 cast predominantly base metal	135*
D2791	Crown, Full cast predominantly base metal	135*
D2910	Recement inlay, onlay or partial coverage restoration	10
D2920	Recement crown	10
D2930	Prefabricated stainless steel crown, primary	35*
D2931	Prefabricated stainless steel crown, permanent	35*
D2950	Core build-up including pins & posts	No Charge
D2951	Pin retention in addition to restoration, per tooth	No Charge
D2952	Cast post and core in addition to crown	25
D2954	Prefabricated post and core in addition to crown	45

Crown, bridge, and denture procedures subject to a 6-month waiting period

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	10
D3310	Root canal therapy, anterior	80
D3320	Root canal therapy, bicuspid	140
D3330	Root canal therapy, molar	195
D3351	Apexification/recalcification - initial visit	10
D3352	Apexification/recalcification - interim visit	10
D3353	Apexification/recalcification - final visit	10
D3410	Apicoectomy, anterior	115
D3421	Apicoectomy, bicuspid, first root	115
D3425	Apicoectomy, molar, first root	115
D3426	Apicoectomy, each additional root	115
D3430	Retrograde filling, per root	25
	PERIODONTICS	
D4210	Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quad	80
D4211	Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quad	10
D4260	Osseous surgery, 4+ contiguous/bounded teeth, per quad	180
D4261	Osseous surgery, 1-3 contiguous/bounded teeth, per quad	90
D4341	Periodontal scaling and root planing, 4+ teeth, per quad	30
D4342	Periodontal scaling and root planing, 1-3 teeth, per quad	15
D4355	Full mouth debridement	23
D4381	Localized delivery of antimicrobial agent, per tooth	35
D4910	Perio maintenance (following active therapy)	28
D4999	Initial perio charting for moderate or advanced cases	5
	PROSTHODONTICS, REMOVABLE	
D5110/5120	Complete upper or lower denture	215*
D5130/5140	Immediate upper or lower denture	250*
D5211/5212	Partial denture, resin base, upper or lower	150*
D5213/5214	Partial denture, cast metal framework, upper or lower	220*
D5410/5411	Adjust complete denture, upper or lower	No Charge
D5421/5422	Adjust partial denture, upper or lower	No Charge
D5820/5821	Interim partial denture, upper or lower	72
D5510	Repair broken complete denture base	20
D5520	Replace missing or broken teeth, complete denture, per tooth	15
D5610	Repair resin denture base	23
D5620	Repair cast framework	38
D5630	Repair or replace broken clasp	25
D5640	Replace broken teeth, per tooth	20
D5650	Add tooth to existing partial denture	20
D5660	Add clasp to existing partial denture	43
D5710/5711	Rebase complete upper or lower denture	68
D5720/5721	Rebase upper or lower partial	68
D5730/5731	Reline complete upper or lower denture, chairside	28
D5740/5741	Reline partial upper or lower denture, chairside	28
D5750/5751	Reline complete upper or lower denture, lab	63
D5760/5761	Reline partial upper or lower denture, lab	63
D5850/5851	Tissue conditioning, upper or lower	15
	PROSTHODONTICS, FIXED	
D6211	Pontic, cast predominantly base metal	135*
D6241	Pontic, porcelain fused to predominantly base metal	170*
D6751	Crown, porcelain fused to predominantly base metal	170*
D6791	Crown, full cast predominantly base metal	135*
D6930	Recement fixed partial denture	15
D6970	Cast post and core in addition to fixed partial denture retainer	45
D6971	Cast post as part of a fixed partial denture retainer	45
D6972	Prefabricated post and core in addition to fixed partial denture retainer	25
D6973	Core buildup for retainer, including pins	12

Crown, bridge, and denture procedures subject to a 6-month waiting period

ADA CODE	PROCEDURE	MEMBER PAYS
	ORAL SURGERY	
D7140	Extraction, erupted tooth or exposed root	12
D7210	Surgical removal of erupted tooth	25
D7220	Removal of impacted tooth, soft tissue	38
D7230	Removal of impacted tooth, partially bony	55
D7240	Removal of impacted tooth, completely bony	70
D7250	Removal of residual tooth roots	25
D7960	Frenulectomy	45
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative treatment, emergency	10
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	28
D9930	Treatment of post-surgical complications	No Charge
	MISCELLANEOUS SERVICES	
D9941	Occlusal guard, athletic	70
D9951	Occlusal adjustment, limited	10
D0470	Diagnostic casts	5
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable appliance therapy	35
D8220	Fixed appliance therapy	55
D8999	Office visit for observation, adjustment or activation, per visit	8
	ELECTIVE SERVICES	
	Resin Restorations-posterior permanent teeth	
D2391	Resin based composite – 1 surface	55
D2392	Resin based composite – 2 surface	80
D2393	Resin based composite – 3 surface	95
D2394	Resin based composite – 4 or more surfaces	115
	Other Elective Procedures	
D2751	Cosmetic crown, porcelain fused to predominantly base metal	350
D2962	Labial veneers, porcelain laminate	335
D6241	Pontic, porcelain fused to predominantly base metal	170
D6751	Crown, porcelain fused to predominantly base metal	170
D9972	Bleaching, per arch	170
	FAILED APPOINTMENTS	
	Failure to cancel appointment (24 hours prior notice)	20
	RECORD TRANSFER	
	Transfer of all materials with less than a full mouth x-ray	10
	Transfer of all materials with a full mouth x-ray	20

Note A: Cost of noble and 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 200 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-$48	Once every three (3) years.
Fluoride	$5	Once every twelve (12) months.
Sealants	$10 per tooth	None
Amalgam fillings (primary or permanent teeth)	$6-$24	None
Resin fillings, anterior (front) teeth	$18-$34	None
Crowns, single restoration	$170-$350	Must be more than five (5) years old for replacement coverage. Subject to a six (6) month waiting period. If crown is placed prior to the completion of the member's wait period, the provider shall perform these services at the fee for elective crowns as detailed in the fee schedule unless otherwise limited elsewhere by the contract.
Root Canal Therapy	$80-$195	Teeth with poor prognosis are not covered for endodontic treatment.
Apicoectomy (first root)	$115	Teeth with poor prognosis are not covered for endodontic treatment.
Osseous surgery	$90-$180	None
Scaling and Root Planing	$15-$30	Limited to one course of therapy in a 12 month period.
Full Mouth Dentures	$215	Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered. Subject to a six (6) month waiting period.
Partial Dentures	$150-$220	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. Subject to a six (6) month waiting period.
Fixed bridge	$345-$390 per unit	Must be more than five (5) years old for replacement coverage. Subject to a six (6) month waiting period.
Extraction of erupted tooth	$12-$25	All treatment of fractures and dislocations are excluded. Extractions for orthodontic purposes are not covered.
Removal of impacted tooth	$38-$70	All treatment of fractures and dislocations are excluded. Extractions for orthodontic purposes are not covered.
Emergency palliative treatment	$10	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.