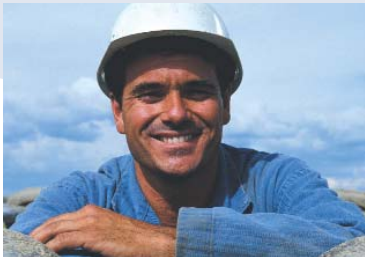


*Something to  
Smile about...*



# Small Group Dental & Vision Sales Guide

*for Businesses with 2-50 Employees*

January 2008



This Sales Guide is a summary of dental and vision plan options available to small groups with 2-50 eligible employees. Plan options include:

√ **HMO Dental**

- No annual maximum or deductible
- No waiting periods
- Comprehensive vision and child/adult orthodontic benefits at no additional cost
- General dentistry and specialty care at the same low copayment level
- Over 3,000 private practice dentists and specialists statewide
- Optional rider for Cosmetic/Elective procedures

√ **PPO Dental**

- National PPO panel with over 51,000 providers
- Flexible plan designs with cost saving features
- Optional orthodontic benefit

√ **Dual Choice options (HMO/PPO)**

- Voluntary and Non-Voluntary dual choice plans available

√ **Voluntary Dental**

- No employer contribution requirement
- Employer can choose any HMO plan alongside our Voluntary PPO plan

√ **Stand-Alone Vision**

- No limitations on contact lenses, eyeglasses or frames
- No limitations on non-prescription glasses and sunglasses
- No employer contribution or participation requirements

**Please contact Sales & Marketing for:**

- Additional PPO plan options available to small groups of 2-50
- Formal proposal
- Large group (50+) quotes
- Questions?
- Forms and supplies

This Sales Guide does not supersede the terms of any Group Policy(s) or Certificate(s) of Coverage applicable to the coverage described within. In the event of a conflict between the terms of this guide and the terms of the Group Policy or Certificate of Coverage, as the case may be, the terms of the Group Policy or Certificate of Coverage will apply. You should refer to the Group Policy(s) and the applicable Certificate(s) of Coverage for specific terms regarding the benefit plans.

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# General Information for Non-Voluntary Dental Plans

## Employer Location

The employer must be situated in the State of California. Golden West DHMO and vision plans are available to California employees only.

## Minimum Case Size

**Stand-alone DHMO:** There must be at least two eligible employees.

**Stand-alone PPO and Dual Choice:** There must be at least 10 eligible employees.

## Employer Contribution and Participation Requirements

**Stand-alone DHMO or PPO:** Employer must contribute a minimum of 50% of employee's monthly premium. 75% of total eligible employees must enroll (excludes employees waiving coverage due to other coverage elsewhere). If employer contributes 100%, then 100% of total eligible employees must enroll.

**Dual Choice:** Employer must contribute a minimum of 75% of employee's monthly DHMO premium and the same dollar amount towards the PPO. 75% of total eligible employees must enroll. If employer contributes 100%, then 100% of total eligible employees must enroll. All employees must be given the option to enroll in either the DHMO or PPO plan.

If an employee is waiving coverage due to other group coverage not through the same employer (as an insured or a dependent), the employee is considered ineligible for the purposes of calculating participation. The employee must submit a Refusal of Coverage and provide the reason coverage is being waived.

Minimum participation requirements must be maintained at all times in order for the group to remain eligible. Groups are subject to cancellation if the participation rate falls below our minimum participation requirements for a period of at least one month.

## Eligible Employees

Employees must be actively at work on the plan's effective date in order to be enrolled. An eligible employee means a permanent full-time employee who has a normal work week of 30 or more hours in the conduct of the group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis working at least 20 hours per week. An eligible employee does not include 1099 employees or employees who work on a part-time, temporary, or substitute basis.

## Eligible Dependents

Dependent coverage is available for the following:

- Lawful spouse or domestic partner of the eligible employee.
- Unmarried dependent child(ren) to age 19, or age 23 if full-time students. Coverage will be extended for dependent children who are mentally or physically disabled and chiefly dependent upon the employee for support.

**Note:** If a husband and wife are both employed by the same company, they must apply separately as employees. Any

children of said employees will be eligible as a dependent only under one employee.

## Prior Deductible Credit

For new group submissions, credit for deductibles met under prior group dental coverage will be given to PPO enrollees, provided proof of the actual dollar amount is submitted with the first claim. In order to receive this credit, there must not be a lapse in coverage between the employer's prior group dental plan and this plan.

## Late Entrant Provision

Employees or dependents who enroll on the PPO plan more than 31 days after their initial eligibility date will be considered a Late Entrant and benefits will be limited to Preventive/Diagnostic services during the first 12 months of coverage.

## Groups could be declined if:

- Employer/employee relationship does not exist.
- The employer does not meet the minimum premium contribution requirement.
- The case does not meet the minimum participation requirement.
- More than 10% of the employees reside outside of the State of California.
- More than 10% of the enrollees are under COBRA or Cal-COBRA continuation.
- The employer is located outside of the State of California.
- The group is in an ineligible category.

## Ineligible Categories

The following types of employer groups are ineligible for Non-Voluntary dental plans.

**Associations** - A group of employer units that are banded together for any reason. Each group must apply separately.

**Multiple Employer Trusts** - Employers, usually in the same or related industries, that are brought together by an insurer, agent, broker or administrator for the purpose of providing insurance for their employees under a master contract issued to a trustee under a trust agreement.

**Taft-Hartley** - A group in a trust established under the authority of the Labor Management Relations Act of 1948. It is comprised of one or more unions and one or more employers who provide coverage for union members. A group contract is issued to the trustees named under the trust agreement, which usually results from collective bargaining.

**Hour Bank Group** - A Taft-Hartley Welfare Fund in which eligibility under the fund is determined by a certain number of hours worked. If an employee works more hours than are needed to maintain eligibility, he/she can put all or a portion of these excess hours in the bank. If an employee works insufficient hours to maintain eligibility, he/she can draw on his/her bank hours.

**Professional Employer Organizations** - Employee leasing firms.

**Private households, unclassifiable occupations, and members of organizations such as credit union or fraternal order members.**

## General Information for Voluntary Dental Plans

### Employer Location

The employer must be situated in the State of California. Golden West DHMO and vision plans are available to California employees only.

### Employer Contribution and Participation Requirements

**Stand-alone DHMO:** Employer can contribute 0-49% of employee's monthly premium. At least 2 employees must enroll in order for the plan to become active and remain in force.

**Stand-alone PPO:** Employer can contribute 0-49% of employee's monthly premium. There must be at least 25% participation or 5 employees must enroll, whichever is greater, in order for the plan to become active and remain in force.

**Dual Choice:** Employer can contribute 0-74% of employee's monthly premium. There must be at least 25% participation. At least 5 employees must enroll on the PPO plan and at least 2 employees must enroll on the HMO plan in order for the plan to become active and remain in force.

### Eligible Employees

Employees must be actively at work on the plan's effective date in order to be enrolled. An eligible employee means a permanent full-time employee who has a normal work week of 30 or more hours in the conduct of the group's business. Sole proprietors and partners are also eligible to enroll if they are actively engaged on a full-time basis. An eligible employee does not include 1099 employees or employees who work on a part-time, temporary, or substitute basis.

### Eligible Dependents

Dependent coverage is available for the following:

- Lawful spouse or domestic partner of the eligible employee.
- Unmarried dependent child(ren) to age 19, or age 23 if full-time students. Coverage will be extended for dependent children who are mentally or physically disabled and chiefly dependent upon the employee for support.

**Note:** If a husband and wife are both employed by the same company, they must apply separately as employees. Any children of said employees will be eligible as a dependent only under one employee.

### Prior Deductible Credit

For new group submissions, credit for deductibles met under prior group dental coverage will be given to PPO enrollees, provided proof of the actual dollar amount is submitted with the first claim.

In order to receive this credit, there must not be a lapse in coverage between the employer's prior group dental plan and this plan.

### Late Entrant Provision

Employees and dependents must enroll within 31 days after their initial eligibility date. If an employee or dependent wishes to enroll more than 31 days after their initial eligibility date, they must wait until annual open enrollment period.

### Groups could be declined if:

- Employer/employee relationship does not exist.
- The case does not meet the minimum participation requirement.
- More than 10% of the employees reside outside of the State of California.
- More than 10% of the enrollees are under COBRA or Cal-COBRA continuation.
- The employer is located outside of the State of California
- The group is in an ineligible category.

### Ineligible Categories

The following types of employer groups are ineligible for Voluntary dental plans.

**Associations** - A group of employer units that are banded together for any reason. Each group must apply separately.

**Multiple Employer Trusts** - Employers, usually in the same or related industries, that are brought together by an insurer, agent, broker or administrator for the purpose of providing insurance for their employees under a master contract issued to a trustee under a trust agreement.

**Taft-Hartley** - A group in a trust established under the authority of the Labor Management Relations Act of 1948. It is comprised of one or more unions and one or more employers who provide coverage for union members. A group contract is issued to the trustees named under the trust agreement, which usually results from collective bargaining.

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**Professional Employer Organizations** - Employee leasing firms.

**Private households, unclassifiable occupations, and members of organizations such as credit union or fraternal order members.**

## Dental HMO Plans Available to Voluntary and Non-Voluntary Groups

Golden West's HMO plans are available to both voluntary and non-voluntary groups, and can be sold alongside our True Advantage PPO and Voluntary PPO plans as a dual option. The Cosmetic/Elective Benefit Rider can be added as an option to all HMO plans. The following is a summary of copayments only. For a complete list of copayments and covered procedures, please contact Sales & Marketing at (800) 219-9216, or visit our web site at [www.goldenwestdental.com](http://www.goldenwestdental.com).

CDT-5	Procedure	Preferred Choice	89L1	89L2	89L3	PA 100
D0120	Periodic exam	\$0	\$0	\$0	\$0	\$0
D0210	Full mouth x-rays	0	0	0	0	0
D1110	Prophylaxis, adult	0	0	0	0	0
D1120	Prophylaxis, child	0	0	0	0	0
D1351	Sealant, per tooth	11	11	9	7	7
	<b>Minor Restorative</b>					
D2140	Amalgam, one surface, primary tooth	10	9	7	0	0
D2140	Amalgam, one surface, permanent tooth	12	9	7	0	0
D2330	Resin restoration, anterior, one surface	16	13	10	8	0
D2951	Pin retention, per tooth	15	13	10	8	0
	<b>Crowns*</b>					
D2751	Crown, porcelain with metal	175	170	150	120	130
D2751	Crown, porcelain with metal (molars)	275	270	250	220	130
D2781	Crown, ¾ cast metal	150	150	140	100	100
D2791	Crown, full cast metal	150	150	140	100	100
D2930	Stainless steel crown, primary tooth	40	25	20	10	0
D2952	Cast post and core in addition to crown	50	40	30	20	20
	<b>Endodontics</b>					
D3110/3120	Pulp cap, direct or indirect	5	0	0	0	0
D3220	Therapeutic pulpotomy	20	0	0	0	0
D3310	Root canal, anterior	100	80	75	50	50
D3330	Root canal, molar	220	195	175	150	125
	<b>Periodontics</b>					
D4210	Gingivectomy/gingivoplasty, 4+ teeth	95	80	70	40	40
D4260	Osseous surgery, 4+ teeth, per quadrant	220	180	160	100	175
D4341	Periodontal scaling & root planing, 4+ teeth, per quadrant	45	35	30	20	20
	<b>Prosthetics*</b>					
D5110/5120	Complete upper or lower denture	195	190	175	150	100
D5211/5212	Partial denture, resin base	165	150	130	120	125
D5410/5411	Adjust complete denture	0	0	0	0	0
D5510	Repair broken complete denture base	30	20	15	0	0
D5740/5741	Reline partial denture, chairside	0	0	0	0	0
D5820/5821	Interim partial denture	70	50	40	20	20
D5850/5851	Tissue conditioning	0	0	0	0	0
	<b>Oral Surgery</b>					
D7140	Extraction of tooth or exposed root	15	10	8	0	0
D7210	Surgical removal of erupted tooth	35	30	20	15	15
D7220	Removal of impacted tooth – soft tissue	50	40	30	20	20
D7230	Removal of impacted tooth – partially bony	85	75	60	30	30
	<b>Orthodontic (Plan 4)</b>					
	Diagnostic work-up (waived if patient proceeds with treatment)	100	100	100	100	100
	Adult or Child – 24 months full treatment	1795	1795	1795	1795	1795
	<b>Vision (Vision Plan 89E)</b>					
	Eye exam	39	39	39	39	39
	Frames and Lenses (includes contact lenses and prescription sunglasses)	25% discount	25% discount	25% discount	25% discount	25% discount
<b>Optional Cosmetic Rider provides benefits for:</b>		<b>Member Copayment</b>				
	Posterior resin restorations	\$65-125				
	Inlays and onlays*	\$240-405				
	Elective crown*	\$390				
	Veneers*	\$330				
	Elective fixed bridgework, per unit*	\$360-390				
	Occlusal guard*	\$150				
	Tooth Whitening Kit	\$90				

\*plus actual dental lab fee where applicable

## Dental PPO Plan Options for Non-Voluntary Groups

Golden West's True Advantage PPO\* plans offer both employers and employees the choices they want for comprehensive, affordable dental care. Employers can choose the plan designs that best suit their needs, and the needs of their employees. Listed below are our most popular plan designs chosen by employer groups of 2-50 eligible employees. Other benefit options are available. Please contact Sales and Marketing at (800) 219-9216 for additional information.

\*Underwritten by UniCare Life & Health Insurance Company, rated A- (Excellent) by A.M. Best Company.

	Plan A		Plan B		Plan C		Plan D	
	In	Out	In	Out	In	Out	In	Out
<b>Preventive/Diagnostic</b> Exams, cleanings, x-rays, fluoride, sealants	100%	100%	100%	100%	100%	90%	100%	80%
<b>Basic Services</b> Fillings, space maintenance, oral surgery, consultations, emergency treatment	90%	80%	80%	80%	80%	70%	80%	80%
<b>Major Services</b> Inlay/onlay, crowns, bridges, dentures	60%	50%	50%	50%	50%	50%	50%	50%
<b>Periodontics/Endodontics</b>	Basic or Major							
<b>Calendar Year Deductible</b>	\$50 Deductible (3x family) Waived for Preventive In-Network or \$50 Deductible (3x family) Waived for Preventive In and Out of Network							
<b>Calendar Year Maximum</b>	\$1000, \$1500, or \$2000							
<b>Orthodontia – Optional**</b>	50% to \$1000, \$1500, or \$2000 for dependent children Coverage for adult/child orthodontia is available as an option							
<b>Waiting Periods</b>	12 months for Major Services and 24 months for Orthodontia (if Orthodontia is included) Takeover groups: Credit for Prior Time will be given for the number of months employee was enrolled on the group's prior dental plan to reduce waiting period(s).  Waiting periods can be waived as an option							
<b>Out of Network Reimbursement Options</b>	<p><b>True Advantage Select:</b> Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.</p> <p><b>True Advantage Standard:</b> Out of network reimbursement is based on a fee schedule. Out of network coinsurance percentages are applied to the fee schedule.</p>							

\*\*HMO Ortho Plan 4 can be added to any PPO dental plan along with HMO Vision Plan 89E at no additional charge. Coverage is for California employees only.

## Dental PPO Plan Options for Voluntary Groups

Next to medical insurance, dental is the single most requested benefit among employees today. Golden West's Voluntary PPO\* plans offer both employers and employees the choices they want for comprehensive, affordable dental care at little or no cost to the employer.

\*Underwritten by UniCare Life & Health Insurance Company, rated A- (Excellent) by A.M. Best Company.

	In Network	Out of Network*
<b>Preventive/Diagnostic</b> Exams, cleanings, x-rays, fluoride, sealants	100%	90%
<b>Basic Services</b> Fillings, space maintenance, oral surgery, consultations, emergency treatment	80%	70%
<b>Major Services</b> Inlay/onlay, crowns, bridges, dentures	50%	50%
<b>Periodontics/Endodontics</b>	Basic or Major	
<b>Calendar Year Deductible</b>	\$50 Deductible (3x family) Waived for Preventive In-Network or \$50 Deductible (3x family) Waived for Preventive In and Out of Network	
<b>Calendar Year Maximum</b>	\$1000 or \$1500	
<b>Orthodontia – Optional**</b>	50% to \$1000 or \$1500 for dependent children Coverage for adult/child orthodontia is available as an option	
<b>Waiting Periods</b>	<p>12 months for Major Services and 24 for Orthodontia (if Orthodontia is included) Takeover groups: Credit for Prior Time will be given for the number of months employee was enrolled on the group's prior dental plan to reduce waiting period(s).</p> <p>For voluntary groups with prior coverage, waiting periods can be waived as an option</p>	

\*Out of network reimbursement is based on a fee schedule. Out of network coinsurance percentages are applied to the fee schedule.

\*\*HMO Ortho Plan 4 can be added to any PPO dental plan along with HMO Vision Plan 89E at no additional charge. Coverage is for California employees only.



## Stand-Alone Vision Plans

Golden West's stand-alone vision plans offer employees and association members a variety of services at significant savings. Minimum group size is 2 lives. There are no employer contribution or participation requirements.

We recognize that many members prefer to have a second pair of contacts or eyeglasses as a convenience. With Golden West's Vision Advantage and 90GE Vision plans, there are NO LIMITATIONS on contact lenses, eyeglass lenses and frames, non-prescription glasses, and sunglasses!

This table is only a sample of member copayments. For a complete list of covered services, limitations and exclusions, please contact Sales & Marketing at (800) 219-9216, or visit our web site at [www.goldenwestdental.com](http://www.goldenwestdental.com).

	Vision Advantage	90GE
<b>Eye Exam (includes glaucoma testing)</b>	\$20	No Charge
<b>Contact Lenses (Soft)</b>		
Regular Soft	\$30 per lens	\$35 per lens
Tinted	\$40 per lens	\$40 per lens
<b>Contact Lenses (Extended Wear)</b>		
Regular Soft	\$33 per lens	\$35 per lens
Tinted	\$43 per lens	\$40 per lens
<b>Contact Lenses (Rigid)</b>		
Gas Permeable Daily Wear	\$48 per lens	\$40 per lens
<b>Complete Fitting &amp; 3-Month Followup</b>		
Daily Wear	\$40	\$40
Gas Permeable	\$70	\$105
Eyeglass Frames	30% Discount	30% Discount
Eyeglass Lenses	30% Discount + various copayments for lens additions	Various copayments
<b>Monthly Premium:</b>		
Employee Only	\$3.00	\$6.85
Employee + Spouse	6.00	12.90
Employee + Child(ren)	6.00	11.90
Family	12.00	19.60

**Principal Limitations & Exclusions:**

- Vision Advantage Plan only: Eye exams limited to one per 12 month period.
- There will be a charge for missed appointments without 24 hours prior notification.
- Follow-up care for contact lenses shall be limited to a period of time not to exceed 3 months. Additional visits are subject to an office visit charge.
- Dispensing or prescribing of drugs is not covered.
- Procedures or services determined by Golden West to be special or unusual including, but not limited to, orthoptics, vision training, and subnormal vision aids.
- 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.
- Medical eye services or hospitalization.
- Treatment required for conditions resulting from major disaster or epidemic or military-service-connected conditions.
- Any experimental procedures.
- Services that cannot be performed because of the general health of the patient.
- A minor fitting fee of \$30 is applicable in lieu of the complete fitting fee if the patient receives contact lenses elsewhere.



Principal limitations and exclusions for the True Advantage Select, Standard, and Voluntary dental PPO plans are described below. This list is a representative overview only. A comprehensive list and more details of each plan's limitations and exclusions can be found in the Certificate of Insurance.

### PRINCIPAL LIMITATIONS

- One examination is allowed in any 6 consecutive month period.
- One prophylaxis or one perio maintenance procedure is allowed in any 6 consecutive month period.
- Child fluoride treatments are limited to once every 6 months.
- Bite wing x-rays are limited to 4 films in any 12 consecutive month period.
- Intraoral complete series (including bitewings), or Panorex, are limited to once every 5 years for insureds age 12 and over.
- Other intraoral x-rays will be covered to a maximum of 4 periapical and two 2 occlusal every 12 months.
- Sealants (one application) are allowed in permanent first and second molars.
- Allowance for space maintainers includes initial appliance only and all adjustment in first 6 months for dependent children to age 16.
- Specialist consultations are limited to 2 visits in any 12 consecutive month period.
- Multiple restorations on one surface will be considered one restoration. Subsequent restorative services performed on same tooth and surface will be limited to the latter procedure.
- Benefits for composite resin restorations on posterior teeth and anterior primary teeth will be based on the corresponding amalgam restoration.
- General anesthesia is allowed only when used in conjunction with covered oral surgical procedures.
- Cast restorations and crowns are covered only when tooth cannot be restored with routine filling material.
- Cast restorations and crowns must be five years old for replacement.
- Deciduous teeth are limited to stainless steel crowns.
- Benefits for noble and high noble metal are based on the corresponding porcelain or base metal crown.
- Post and core limited to endodontically treated teeth.
- Gingivectomy and gingivoplasty is limited to once every 36 months.
- Gingival flap procedure is limited to once every 36 months.
- Osseous surgery is limited to once every 36 months, and applied to other perio/surgical procedures performed in same area in same 36 month period.
- Periodontal scaling and root planing is limited to 4 quadrants in any 24 consecutive month period.
- Full mouth debridement is limited to once in any 24 consecutive month period.
- Denture adjustments are covered only after 6 months from time of initial denture placement.
- Denture repairs are covered only after 12 months from time of initial denture placement.
- Denture relines are limited to once per denture in any 24 consecutive months period after 12 months from time of initial denture placement.
- Coverage for interim partial dentures is limited to anterior teeth.
- Tissue conditioning is limited to 2 treatments per arch in any 12 consecutive month period.
- Coverage for bridgework is limited to insureds age 16 and over.

### PRINCIPAL EXCLUSIONS

- Experimental or Investigative Procedures. Any procedures which are considered *experimental* or *investigative* or which are not widely accepted as proven and effective procedures within the organized dental community.
- Excess Expense. Any amounts in excess of *covered dental expense* or the Dental Benefit Maximums.
- Professionally Acceptable Treatment. If we determine that more than one treatment plan would be considered a *covered service* for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.
- Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed *dentist* or physician, except charges for dental prophylaxis performed by a licensed dental hygienist.
- Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. These include but are not limited to changing the vertical dimension; replacing or stabilizing tooth structure lost by attrition, abrasion, erosion, or bruxism; realignment of teeth; gnathological recording; occlusal equilibration (but not excluding such treatment needed to treat periodontal disease); periodontal splinting; treatment related to temporomandibular joint (jaw joint) disturbances and/or hormonal imbalance; nightguards, harmful habit and thumbsucking devices.
- Prosthetic Replacements. Replacement of fixed or removable prosthesis, if replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth.
- Prosthetics for Teeth Extracted Prior to Coverage. Initial placement of prosthetics if teeth being replaced were missing before the *insured person* was covered by this *Plan*.
- Crown, Inlay, Onlay Replacements. Replacement of crowns and cast restorations, if replacement occurs within five years of the original placement.
- Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen.
- Making a spare appliance or prosthetic device.
- Cosmetic Dentistry. Any services performed for cosmetic purposes, including, but not limited to facings on crowns or pontics posterior to the second bicuspid.
- Nitrous oxide. Charges for nitrous oxide, Novocain, Xylocaine or any similar local anesthetic when the charge is made separately from a covered dental expense.
- Personalization. Personalization of dentures or teeth, or precision attachments.
- Oral surgery for or on: disturbances of the temporomandibular joint; fractures of the jaw; resectioning of the bone; repositioning of the teeth or bone implantation, re-implantation or transplantation, or salivary gland, duct or sinus.
- Congenital or developmental malformations. Treatment of congenital or developmental malformations.
- Treatment, services or supplies received while hospitalized as an inpatient or on an outpatient basis.
- Bonding or grafting. Procedures related to bonding or grafting.
- Overdentures.
- Oral hygiene, plaque control, diet instruction.
- Orthodontic treatment, unless orthodontic rider is attached.

## DHMO Limitations and Exclusions

Principal limitations and exclusions for the DHMO plans are described below. This list is a representative overview only. A comprehensive list and more details of each plan's limitations and exclusions can be found in the Evidence of Coverage (EOC).

### LIMITATIONS

- Routine and periodic examinations are limited to once every six (6) months.
  - Prophylaxis is limited to once every six (6) months.
  - Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one series of films in any twelve (12) consecutive month period.
  - Full mouth radiographs (x-rays) and Panorex are limited to once every three (3) years.
  - Fluoride treatment is limited to once every twelve (12) months.
  - Sealants are allowed in permanent first and second molars up to the age of sixteen (16).
  - Space maintainers are allowed only for dependent children up to the age of sixteen (16).
  - Stainless steel crowns on permanent teeth are allowed up to the age of nineteen (19).
  - Temporary restorations, all adhesives (including amalgam bonding agents) liners and bases, impressions and local anesthesia are considered components of the fee for the completed restoration.
  - Benefits for the treatment of rampant caries are limited to the first seven (7) most severely decayed primary teeth, subject to all plan limitations. Rampant caries is defined as eight (8) or more decayed primary teeth.
  - Cast restorations and crowns are covered only when extensive coronal destruction is radiographically evident and tooth cannot be restored with an intracoronal restoration, unless tooth is diagnosed as having cracked tooth syndrome.
  - The use of noble and high noble metal for any restorative procedure will be charged to the MEMBER at the additional laboratory cost of the noble or high noble metal. Copayments do not include charges for gold or dental laboratory fees.
  - Complete and/or partial denture relines are limited to one per denture during any twelve (12) month period.
  - Complete or partial upper and/or lower dentures are limited to the benefit level for a standard procedure. If a more personalized or specialized treatment (such as precision attachments, overlays, implants, personalization or characterization) is chosen by the MEMBER and the dentist, the MEMBER will be responsible for all additional charges.
  - A fixed bridge in any posterior quadrant, when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic, is considered elective. An alternate benefit for a partial denture would be allowed. See Alternate Benefit Provision, Section XVI.
  - Gingival Curettage and Periodontal Scaling and Root Planing are limited to four (4) quadrants per calendar year if periodontal disease is present. No more than two (2) quadrants per service date are allowed.
  - Osseous surgery is limited to four (4) quadrants per lifetime.
  - One treatment of Actisite for replacement of fiber material is allowed within ten (10) days of initial placement.
5. Treatment rendered by a SPECIALIST if MEMBER is deemed unmanageable for treatment by any Network General Dentist, except for covered dependent children up to the age limit stated on Specialty Referral Exhibit D if specialty care is included.
  6. Conditions resulting from disease or epidemic or injuries sustained as a result of a major disaster or war (declared or undeclared).
  7. Dental procedures initiated prior to MEMBER'S eligibility under this benefit plan or started after MEMBER'S termination from the plan.
  8. Services performed for cosmetic, elective, or aesthetic purposes, unless the policy includes a Cosmetic/Elective Benefit Rider (Exhibit E).
  9. Dental laboratory fees including the cost of noble and high noble metal.
  10. Services or supplies that do not meet accepted standards of dental practice, which are experimental in nature or are considered enhancements to standard dental care.
  11. Implants and services incurred as part of implants, and fixed or removable prosthetics placed on implants.
  12. Treatment related to temporomandibular joint syndrome (TMJ).
  13. Appliances, restorations, or procedures to alter vertical dimension, restore or maintain occlusion, splint or stabilize teeth for periodontic reasons, replace tooth structure lost as a result of abrasion, erosion, or attrition, or treat bruxism (nightguards, harmful habit and thumbsucking devices).
  14. Treatment and/or services (including biopsy) for malignancies, cysts, neoplasms, or congenital or developmental malformations.
  15. General anesthesia, analgesia (including nitrous oxide), sedation, and prescription drugs.
  16. Any inpatient/outpatient hospital or surgicenter charges of any kind including physician charges, prescriptions or medication.
  17. Treatment for crown exposure, ligation, and crown lengthening.
  18. Replacement of an appliance or fixed or removable prosthetic with a like appliance or prosthetic unless the appliance or prosthetic is at least 5 years old and cannot be made usable. Replacement of crowns unless existing crown is more than five (5) years old.
  19. Replacement of a lost, stolen, or missing appliance or prosthetic device, glasses, or contacts.
  20. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction (six or more units of crown and/or bridgework in one arch or more than ten units total).
  21. Resectioning of the bone and surgeries involving repositioning of the teeth or tooth implantation, re-implantation or transplantation.
  22. Oral surgery for fractures or dislocations of the jaw, resectioning of the bone, repositioning of the teeth or bone implantation or transplantation, salivary gland, duct or sinus. Orthognathic surgery and extractions for orthodontic purposes.
  23. Elective oral surgery, including the extraction of non-pathologic, asymptomatic teeth, overretained deciduous teeth, and deciduous teeth which appear to be at or near exfoliation.

### EXCLUSIONS

1. Any procedure not specifically listed as a covered service.
2. Any dental treatment which, in the opinion of the attending dentist, is not necessary for the patient's dental health, will not produce a beneficial result, or has a poor prognosis.
3. Services for injuries or conditions for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, medical health insurance, Worker's Compensation or Employer's Liability Laws.
4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political

## DHMO Rates for Voluntary and Non-Voluntary Groups

### Non-Voluntary DHMO Rates Effective 1/1/08 – 12/31/08

<b>2-24 Enrolled Employees</b>	<b>Preferred Choice</b>	<b>89L1</b>	<b>89L2</b>	<b>89L3</b>	<b>89L123</b>	<b>89L23</b>	<b>PA 100</b>
Employee	\$ 8.11	\$ 13.23	\$ 13.77	\$ 15.20	\$ 13.50	\$ 14.04	\$ 16.02
Employee + Spouse	13.90	25.01	25.82	27.53	25.32	26.33	28.29
Employee + Child(ren)	13.04	23.81	24.57	26.37	24.10	25.07	27.04
Family	20.86	31.64	32.58	36.50	31.94	33.23	41.12
<b>25-50 Enrolled Employees</b>							
Employee	\$ 8.11	\$ 12.94	\$ 13.49	\$ 14.92	\$ 13.23	\$ 13.76	\$ 16.02
Employee + Spouse	13.90	23.81	24.58	26.37	24.11	25.08	28.29
Employee + Child(ren)	13.04	22.61	23.35	25.21	22.90	23.82	27.04
Family	20.86	30.44	31.34	35.35	30.74	31.97	41.12

#### Includes Cosmetic Rider

<b>2-24 Enrolled Employees</b>	<b>Preferred Choice</b>	<b>89L1</b>	<b>89L2</b>	<b>89L3</b>	<b>89L123</b>	<b>89L23</b>	<b>PA 100</b>
Employee	\$ 10.00	\$ 15.12	\$ 15.66	\$ 17.09	\$ 15.39	\$ 15.93	\$ 17.91
Employee + Spouse	16.06	27.17	27.98	29.69	27.48	28.49	30.46
Employee + Child(ren)	15.21	25.97	26.74	28.53	26.26	27.23	29.20
Family	23.30	34.07	35.01	38.94	34.37	35.66	43.56
<b>25-50 Enrolled Employees</b>							
Employee	\$ 10.00	\$ 14.83	\$ 15.38	\$ 16.81	\$ 15.12	\$ 15.65	\$ 17.91
Employee + Spouse	16.06	25.97	26.75	28.53	26.27	27.25	30.46
Employee + Child(ren)	15.21	24.77	25.51	27.38	25.06	25.98	29.20
Family	23.30	32.87	33.78	37.78	33.17	34.41	43.56

### Voluntary DHMO Rates Effective 1/1/08 – 12/31/08

<b>2-24 Enrolled Employees</b>	<b>Preferred Choice</b>	<b>89L1</b>	<b>89L2</b>	<b>89L3</b>	<b>89L123</b>	<b>89L23</b>	<b>PA 100</b>
Employee	\$ 8.69	\$ 13.79	\$ 14.34	\$ 15.76	\$ 14.07	\$ 14.63	\$ 16.02
Employee + Spouse	14.49	25.92	26.73	28.69	26.21	27.26	28.29
Employee + Child(ren)	13.62	24.70	25.51	27.53	25.01	26.02	27.04
Family	21.45	32.85	33.81	37.66	33.14	34.81	41.12
<b>25-50 Enrolled Employees</b>							
Employee	\$ 8.69	\$ 13.50	\$ 14.07	\$ 15.48	\$ 13.79	\$ 14.34	\$ 16.02
Employee + Spouse	14.49	24.70	25.51	27.53	25.01	26.02	28.29
Employee + Child(ren)	13.62	23.50	24.28	26.37	23.81	24.78	27.04
Family	21.45	31.65	32.58	36.50	31.94	33.22	41.12

#### Includes Cosmetic Rider

<b>2-24 Enrolled Employees</b>	<b>Preferred Choice</b>	<b>89L1</b>	<b>89L2</b>	<b>89L3</b>	<b>89L123</b>	<b>89L23</b>	<b>PA 100</b>
Employee	\$ 10.58	\$ 15.68	\$ 16.23	\$ 17.65	\$ 15.96	\$ 16.53	\$ 17.91
Employee + Spouse	16.66	28.08	28.89	30.86	28.37	29.42	30.46
Employee + Child(ren)	15.78	26.87	27.68	29.69	27.17	28.19	29.20
Family	23.88	35.28	36.24	40.09	35.57	37.24	43.56
<b>25-50 Enrolled Employees</b>							
Employee	\$ 10.58	\$ 15.39	\$ 15.96	\$ 17.37	\$ 15.68	\$ 16.23	\$ 17.91
Employee + Spouse	16.66	26.87	27.68	29.69	27.17	28.19	30.46
Employee + Child(ren)	15.78	25.67	26.45	28.53	25.97	26.94	29.20
Family	23.88	34.08	35.01	38.94	34.37	35.65	43.56

## Rates for Non-Voluntary PPO Plan Options

The rates on the following pages for Non-Voluntary PPO plans are applicable for PPO plans sold on a stand-alone or dual option basis with Employer Contribution of 50-99% of the employee only premium. If employer contributes 100% of employee only PPO premium, please contact Sales & Marketing for applicable PPO rates.

Plan option rate loads for Areas 1-8 are as follows:

Adjustment Factors – Multiply Rate by:

- \$2,000 Calendar Year Max:
  - Standard Plan - \$1500 max rate x 1.04
  - Select Plan - \$1500 max rate x 1.05
- Waive 12 month waiting period for Major services (Takeover Groups only): 1.05
- Waive deductible for preventive services in and out of network: Submit request to Golden West Sales & Marketing for rates

To include PPO Orthodontia (24 month waiting period applies), add the following to the rates listed above:

	\$1,000 Child Only	\$1,500 Child Only	\$2,000 Child Only	\$1,000 Child/Adult	\$1,500 Child/Adult
EE Only	0	0	0	\$.85	\$1.07
EE + Spouse	0	0	0	\$1.70	\$2.14
EE + Child(ren)	\$8.64	\$10.12	\$11.88	\$9.49	\$11.19
Family	\$8.64	\$10.12	\$11.88	\$10.34	\$12.26

To include PPO Orthodontia (24 month waiting period waived), add the following to the rates listed above:

	\$1,000 Child Only	\$1,500 Child Only	\$2,000 Child Only	\$1,000 Child/Adult	\$1,500 Child/Adult
EE Only	0	0	0	\$.94	\$1.19
EE + Spouse	0	0	0	\$1.89	\$2.38
EE + Child(ren)	\$9.21	\$11.24	\$13.19	\$10.15	\$12.43
Family	\$9.21	\$11.24	\$13.19	\$11.10	\$16.62

# Rates for Non-Voluntary PPO Plan Options

## Rates Effective 1/1/08– 12/31/08

### Area 1

Employer Zip Code: 900-906, 913-916, 918

#### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	38.99	44.99	43.47	50.17	36.07	41.76	40.79	47.29
EE + Spouse	93.91	108.65	104.94	121.42	86.70	100.67	98.27	114.23
EE+ Child(ren)	91.42	105.78	102.17	118.21	84.40	98.00	95.66	111.21
Family	138.93	160.89	155.40	179.95	128.13	148.89	145.35	169.12

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	33.64	38.82	37.51	43.28	33.92	39.17	38.46	44.46
EE + Spouse	80.86	93.55	90.36	104.54	81.54	94.39	92.66	107.40
EE+ Child(ren)	78.71	91.08	87.97	101.77	79.37	91.90	90.21	104.55
Family	119.49	138.37	133.65	154.76	120.50	139.62	137.06	159.00

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

#### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	35.36	39.54	37.28	41.74	32.53	35.76	34.46	37.92
EE + Spouse	71.41	79.86	75.30	84.29	65.69	72.22	69.61	76.58
EE+ Child(ren)	69.53	77.76	73.31	82.08	63.97	70.32	67.77	74.56
Family	105.60	118.10	111.35	124.66	97.15	106.80	102.93	113.25

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	31.34	34.48	32.92	36.26	31.46	34.62	33.39	36.77
EE + Spouse	63.30	69.64	66.47	73.21	63.53	69.92	67.44	74.27
EE+ Child(ren)	61.62	67.81	64.72	71.29	61.86	68.08	65.66	72.32
Family	93.60	102.99	98.30	108.27	93.95	103.40	99.73	109.84

\*Out of network reimbursement is based on a fee schedule.

## Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

### Area 2

Employer Zip Code: 907-912, 917

#### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	42.13	48.62	46.98	54.22	39.03	45.20	44.14	51.18
EE + Spouse	85.16	98.53	95.16	110.11	78.62	91.28	89.11	103.59
EE+ Child(ren)	82.90	95.91	92.64	107.19	76.55	88.88	86.77	100.86
Family	125.91	145.80	140.83	163.08	116.18	135.00	131.78	153.34

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	36.41	42.01	40.59	46.84	36.71	42.39	41.62	48.11
EE + Spouse	73.32	84.83	81.94	94.80	73.94	85.60	84.03	97.39
EE+ Child(ren)	71.40	82.61	79.78	92.31	71.99	83.35	81.82	94.83
Family	108.35	125.46	121.19	140.32	109.25	126.60	124.28	144.16

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

#### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	34.16	38.15	36.34	40.64	31.43	34.50	33.60	36.93
EE + Spouse	68.99	77.04	73.40	82.08	63.46	69.67	67.86	74.56
EE+ Child(ren)	67.18	75.01	71.47	79.93	61.80	67.83	66.06	72.61
Family	102.03	113.92	108.55	121.39	93.85	103.03	100.34	110.28

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	30.28	33.26	32.09	35.31	30.39	33.39	32.55	35.81
EE + Spouse	61.15	67.18	64.80	71.29	61.38	67.45	65.74	72.32
EE+ Child(ren)	59.54	65.42	63.09	69.41	59.77	65.67	64.01	70.42
Family	90.43	99.35	95.84	105.43	90.76	99.75	97.22	106.95

\*Out of network reimbursement is based on a fee schedule.

## Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

### Area 3

Employer Zip Code: 923-929

#### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	42.77	49.35	47.68	55.03	39.59	45.85	44.77	51.92
EE + Spouse	86.40	99.96	96.55	111.70	79.79	92.64	90.44	105.13
EE+ Child(ren)	84.13	97.34	94.01	108.78	77.67	90.18	88.03	102.34
Family	127.77	147.96	142.92	165.50	117.88	136.99	133.73	155.60

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	36.91	42.61	41.16	47.51	37.23	42.99	42.22	48.81
EE + Spouse	74.41	86.09	83.15	96.22	75.04	86.88	85.29	98.84
EE+ Child(ren)	72.44	83.81	80.95	93.65	73.04	84.56	83.02	96.22
Family	109.94	127.31	122.97	142.40	110.86	128.46	126.11	146.29

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

#### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	34.70	38.75	36.97	41.33	31.92	35.05	34.17	37.55
EE + Spouse	70.08	78.26	74.65	83.48	64.47	70.77	69.00	75.84
EE+ Child(ren)	68.23	76.20	72.69	81.29	62.78	68.91	67.20	73.84
Family	103.65	115.73	110.40	123.47	95.34	104.67	102.06	112.15

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	30.76	33.79	32.64	35.89	30.88	33.93	33.10	36.43
EE + Spouse	62.12	68.25	65.90	72.50	62.35	68.52	66.86	73.55
EE+ Child(ren)	60.49	66.45	64.17	70.60	60.71	66.72	65.09	71.61
Family	91.86	100.93	97.46	107.22	92.20	101.34	98.87	108.78

\*Out of network reimbursement is based on a fee schedule.



## Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

### Area 4

Employer Zip Code: 919-921, 942

#### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	39.12	45.14	43.61	50.33	36.21	41.94	40.95	47.49
EE + Spouse	78.90	91.29	88.18	102.03	72.88	84.62	82.61	96.02
EE+ Child(ren)	76.82	88.89	85.85	99.33	70.97	82.39	80.43	93.51
Family	116.63	135.05	130.45	151.06	107.60	125.04	122.06	142.02

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	33.78	38.98	37.66	43.46	34.06	39.33	38.62	44.65
EE + Spouse	67.96	78.63	75.96	87.89	68.54	79.35	77.90	90.29
EE+ Child(ren)	66.18	76.57	73.96	85.57	66.73	77.26	75.85	87.91
Family	100.35	116.21	112.24	129.99	101.20	117.26	115.11	133.53

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

#### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	31.99	35.74	34.23	38.29	29.44	32.32	31.64	34.79
EE + Spouse	64.62	72.18	69.12	77.32	59.44	65.28	63.89	70.24
EE+ Child(ren)	62.92	70.28	67.31	75.28	57.88	63.56	62.22	68.39
Family	95.56	106.74	102.22	114.34	87.91	96.53	94.50	103.86

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	28.37	31.17	30.22	33.25	28.47	31.30	30.65	33.73
EE + Spouse	57.27	62.94	61.03	67.15	57.49	63.19	61.91	68.12
EE+ Child(ren)	55.76	61.28	59.42	65.38	55.98	61.53	60.27	66.33
Family	84.70	93.07	90.26	99.31	85.02	93.45	91.55	100.74

\*Out of network reimbursement is based on a fee schedule.

# Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

## Area 5

Employer Zip Code: 922, 930-931, 934

### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	40.94	47.25	45.65	52.68	37.91	43.89	42.87	49.70
EE + Spouse	82.66	95.63	92.37	106.88	76.36	88.65	86.54	100.60
EE+ Child(ren)	80.47	93.11	89.92	104.04	74.29	86.26	84.21	97.89
Family	122.20	141.52	136.70	158.28	112.73	131.00	127.88	148.79

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	35.35	40.79	39.41	45.49	35.65	41.16	40.42	46.73
EE + Spouse	71.20	82.38	79.57	92.06	71.80	83.13	81.60	94.58
EE+ Child(ren)	69.29	80.17	77.44	89.59	69.88	80.89	79.41	92.04
Family	105.14	121.75	117.60	136.18	106.01	122.84	120.59	139.89

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	32.61	36.46	34.47	38.62	29.99	32.97	31.88	35.08
EE + Spouse	65.84	73.62	69.65	77.99	60.56	66.59	64.38	70.85
EE+ Child(ren)	64.11	71.69	67.81	75.93	58.96	64.84	62.68	68.98
Family	97.36	108.89	102.99	115.33	89.55	98.47	95.20	104.77

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	28.89	31.80	30.45	33.53	29.00	31.92	30.89	34.02
EE + Spouse	58.35	64.21	61.48	67.74	58.57	64.47	62.37	68.71
EE+ Child(ren)	56.82	62.52	59.88	65.94	57.02	62.78	60.74	66.91
Family	86.29	94.95	90.94	100.17	86.62	95.34	92.24	101.62

\*Out of network reimbursement is based on a fee schedule.

# Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

## Area 6

Employer Zip Code: 949-951

### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	42.44	48.98	47.33	54.62	39.28	45.48	44.41	51.49
EE + Spouse	85.85	99.32	95.94	110.99	79.26	92.03	89.83	104.44
EE+ Child(ren)	83.57	96.69	93.40	108.05	77.16	89.59	87.45	101.66
Family	126.98	147.03	142.02	164.46	117.13	136.10	132.86	154.58

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	36.62	42.27	40.83	47.13	36.94	42.65	41.88	48.42
EE + Spouse	73.93	85.54	82.61	95.58	74.54	86.30	84.72	98.18
EE+ Child(ren)	71.96	83.26	80.42	93.03	72.57	84.00	82.47	95.58
Family	109.22	126.49	122.17	141.47	110.14	127.62	125.29	145.34

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	34.31	38.38	36.07	40.40	31.56	34.72	33.35	36.70
EE + Spouse	69.30	77.53	72.86	81.59	63.75	70.11	67.35	74.11
EE+ Child(ren)	67.48	75.49	70.95	79.44	62.08	68.27	65.58	72.17
Family	102.49	114.65	107.74	120.67	94.28	103.69	99.60	109.61

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	30.42	33.48	31.84	35.09	30.52	33.62	32.31	35.60
EE + Spouse	61.42	67.61	64.31	70.86	61.66	67.89	65.25	71.88
EE+ Child(ren)	59.81	65.84	62.63	68.99	60.04	66.10	63.54	69.99
Family	90.84	99.99	95.12	104.79	91.17	100.38	96.49	106.32

\*Out of network reimbursement is based on a fee schedule.

## Rates for Non-Voluntary PPO Plan Options

### Rates Effective 1/1/08– 12/31/08

#### Area 7

Employer Zip Code: 936-939, 952-954, 956-958

#### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	38.09	43.98	42.48	49.02	35.27	40.85	39.88	46.25
EE + Spouse	76.97	89.06	86.01	99.52	71.09	82.53	80.57	93.66
EE+ Child(ren)	74.94	86.71	83.75	96.91	69.20	80.33	78.42	91.16
Family	113.83	131.81	127.31	147.43	105.02	122.04	119.13	138.61

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	32.90	37.95	36.68	42.31	33.17	38.30	37.61	43.48
EE + Spouse	66.29	76.70	74.08	85.71	66.85	77.39	75.97	88.05
EE+ Child(ren)	64.53	74.66	72.11	83.43	65.07	75.33	73.95	85.71
Family	97.95	113.41	109.54	126.86	98.77	114.44	112.34	130.31

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

#### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	30.89	34.50	32.91	36.80	28.41	31.20	30.42	33.43
EE + Spouse	62.39	69.66	66.45	74.31	57.39	63.00	61.43	67.51
EE+ Child(ren)	60.75	67.82	64.70	72.36	55.88	61.34	59.81	65.73
Family	92.26	103.03	98.27	109.90	84.87	93.17	90.85	99.84

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	27.38	30.08	29.05	31.96	27.48	30.20	29.46	32.42
EE + Spouse	55.30	60.75	58.67	64.54	55.50	60.99	59.51	65.47
EE+ Child(ren)	53.84	59.16	57.13	62.85	54.04	59.39	57.94	63.75
Family	81.78	89.85	86.76	95.45	82.08	90.20	88.02	96.83

\*Out of network reimbursement is based on a fee schedule.

# Rates for Non-Voluntary PPO Plan Options

Rates Effective 1/1/08– 12/31/08

## Area 8

Employer Zip Code: 932-933, 935, 940-941, 943-948, 955, 959-961

### Select PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	37.81	43.63	42.16	48.66	35.01	40.54	39.59	45.90
EE + Spouse	76.35	88.33	85.32	98.71	70.52	81.87	79.93	92.91
EE+ Child(ren)	74.33	83.05	83.05	96.09	68.62	79.67	77.77	90.42
Family	112.87	130.70	126.24	146.20	104.12	120.99	118.12	137.43

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	32.65	37.67	36.41	42.01	32.92	38.02	37.34	43.16
EE + Spouse	65.76	76.10	73.49	85.03	66.32	76.78	75.37	87.35
EE+ Child(ren)	64.00	74.04	71.51	82.75	64.53	74.71	73.34	85.01
Family	97.10	112.44	108.62	125.78	97.91	113.45	111.38	129.20

\*Out of network reimbursement is set at a level that is within the common range of fees billed by a majority of dentists for a procedure in a given geographic region.

### Standard PPO Plan\*

	Option A – 100/90/60 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option B – 100/80/50 in, 100/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	30.59	34.20	32.35	36.22	30.51	30.93	29.91	32.91
EE + Spouse	61.75	69.07	65.33	73.16	56.81	62.46	60.39	66.46
EE+ Child(ren)	60.12	67.25	63.61	71.24	55.31	60.83	58.80	64.71
Family	91.32	102.15	96.62	108.18	84.01	92.38	89.32	98.28

	Option C – 100/80/50 in, 90/70/50 out, \$50 deductible WP in-network, Waiting period(s) apply				Option D – 100/80/50 in, 80/80/50 out, \$50 deductible WP in-network, Waiting period(s) apply			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	27.11	29.83	28.56	31.46	27.21	29.94	28.98	31.91
EE + Spouse	54.73	60.23	57.68	63.53	54.94	60.48	58.50	64.45
EE+ Child(ren)	53.30	58.64	56.16	61.86	53.49	58.88	56.97	62.76
Family	80.95	89.08	85.30	93.96	81.25	89.42	86.52	95.32

\*Out of network reimbursement is based on a fee schedule.

## Rates for Voluntary PPO Plan Options

### Rates Effective 1/1/08– 12/31/08

	Area 1 Employer Zip Codes 900-906, 913-916, 918				Area 2 Employer Zip Codes 907-912, 917			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	36.39	40.56	40.01	44.64	35.15	39.19	38.62	43.06
EE + Spouse	73.47	82.11	80.83	90.34	70.98	79.32	77.98	87.15
EE+ Child(ren)	71.54	79.94	78.71	87.94	69.12	77.24	75.93	84.86
Family	108.66	121.54	119.53	133.70	104.97	117.40	115.32	129.00

	Area 3 Employer Zip Codes 923-929				Area 4 Employer Zip Codes 919-921, 942			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	35.70	39.81	39.21	43.73	32.92	36.71	37.61	41.93
EE + Spouse	72.11	80.59	79.22	88.52	66.48	74.30	73.05	81.64
EE+ Child(ren)	70.21	78.46	77.13	86.19	64.75	72.35	71.15	79.51
Family	106.64	119.28	117.16	131.05	98.30	109.95	108.04	120.85

	Area 5 Employer Zip Codes 922, 930-931, 934				Area 6 Employer Zip Codes 949-951			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	33.54	37.41	36.89	41.14	34.31	38.25	37.77	42.11
EE + Spouse	67.74	75.70	74.53	83.29	69.29	77.43	76.27	85.23
EE+ Child(ren)	65.96	73.72	72.59	81.11	67.47	75.38	74.26	82.98
Family	100.17	112.04	110.24	123.30	102.47	114.62	112.78	126.14

	Area 7 Employer Zip Codes 936-939, 952-954, 956-958				Area 8 Employer Zip Codes 932-933, 935, 940-941, 943-948, 955, 959-961			
	Endo/Perio in Major		Endo/Perio in Basic		Endo/Perio in Major		Endo/Perio in Basic	
	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max	\$1000 Max	\$1500 Max
EE Only	31.81	35.48	34.95	38.96	30.89	34.43	33.98	37.89
EE + Spouse	64.26	71.82	70.59	78.89	62.37	69.70	68.63	76.69
EE+ Child(ren)	62.55	69.92	68.73	76.81	60.74	67.86	66.83	74.68
Family	95.03	106.29	104.39	116.77	92.24	103.17	101.50	113.53

Adjustment Factors – Multiply Rate by:

- Waive 12 month waiting period for Major services for Takeover Groups: 1.05
- Waive deductible for preventive services in and out of network: Submit request to Golden West Sales & Marketing for rates.

To include PPO Orthodontia (includes 24 month waiting period), add the following to the rates listed above:

	\$1,000 Child Only	\$1,500 Child Only	\$1,000 Child/Adult	\$1,500 Child/Adult
EE Only	0	0	\$.85	\$1.07
EE + Spouse	0	0	\$1.70	\$2.14
EE + Child(ren)	\$8.64	\$10.12	\$9.49	\$11.19
Family	\$8.64	\$10.12	\$10.34	\$12.26

To include PPO Orthodontia (24 month waiting period waived), add the following to the rates listed above:

	\$1,000 Child Only	\$1,500 Child Only	\$1,000 Child/Adult	\$1,500 Child/Adult
EE Only	0	0	\$.94	\$1.19
EE + Spouse	0	0	\$1.89	\$2.38
EE + Child(ren)	\$9.21	\$11.24	\$10.15	\$12.43
Family	\$9.21	\$11.24	\$11.10	\$16.62

1. Complete, sign and date the Agent's Declaration section of the Group Master Application.
2. Review all forms to make sure they are complete. Employee applications should be completed in the applicant's own handwriting in black ink.
3. Submit all necessary forms including:
  - Copy of proposal or rate sheet.
  - Group Master Application.
  - Employee enrollment forms from all employees/dependents requesting coverage. If employee is enrolling in the HMO plan, they must indicate their dental office selection in the space provided.
  - For non-voluntary plans - Employee Enrollment Forms from all employees declining coverage. Coverage Declination section must be completed and signed.
  - Binder check equal to first month's premium.
  - Agent licensing paperwork if first case with Golden West.
    - Agent Profile/Service Agreement
    - UNICARE Agent/Agency Appointment form
    - Copy of current L&D license
    - Copy of Errors & Omissions insurance face page
    - W-9 Form

**Note:** PPO enrollees can receive Credit for Prior Time to reduce waiting periods if group is being taken over from a prior carrier. Please submit a copy of the prior carrier bill and benefits booklet or certificate of coverage. If the prior carrier billing does not indicate employee's effective date on the prior plan, a separate list showing employee's effective date on prior plan should be included to insure proper credit.

Effective dates must be the first of the month only. Applications must be received by Golden West on or before the 10<sup>th</sup> of the month of the requested effective date.

Please submit all paperwork to:

**By US Mail:**

Golden West Dental & Vision  
Attn: Sales & Marketing  
PO Box 5347  
Oxnard, CA 93031-5347

**Overnight:**

Golden West Dental & Vision  
Attn: Sales & Marketing  
5171 Verdugo Way  
Camarillo, CA 93012

Additional forms can be printed in PDF format from our website: [www.goldenwestdental.com](http://www.goldenwestdental.com)