

PACESETTER DENTAL PLAN COPAYMENT SCHEDULE

Services must be performed by your Golden West Network General Dentist subject to the following copayments.
Services not listed are available on a fee-for-service basis at your dental office.

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
D0270/0272/0274	Bitewing x-rays	No Charge
D0330	Panoramic film	No Charge
CLEANINGS AND PREVENTIVE SERVICES		
D1110/1120	Prophylaxis – adult or child	No Charge
D1201	Fluoride treatment, child	No Charge
D1351	Sealant, per tooth	20
SPACE MAINTAINERS		
D1510/1515	Space maintainer, fixed	75
D1550	Recement space maintainer	No Charge
RESTORATIONS		
D2140	Amalgam, 1 surface, primary or permanent	8
D2150	Amalgam, 2 surfaces, primary or permanent	16
D2160	Amalgam, 3 surfaces, primary or permanent	24
D2161	Amalgam, 4 or more surfaces, primary or permanent	32
D2330	Resin based composite, 1 surface, anterior (permanent teeth)	25
D2331	Resin based composite, 2 surfaces, anterior (permanent teeth)	50
D2332	Resin based composite, 3 surfaces, anterior (permanent teeth)	75
D2335	Resin based composite, 4 or more surfaces/incisal angle, anterior (permanent teeth)	100
CROWNS		
D2740	Porcelain/ceramic substrate	150
D2751	Porcelain fused to predominantly base metal	250
D2781	3/4 cast predominantly base metal	200
D2791	Full cast predominantly base metal	200
D2910	Recement inlay, onlay or partial coverage restoration	No Charge
D2915	Recement cast or prefabricated post and core	No Charge
D2920	Recement crown	No Charge
D2930	Prefabricated stainless steel, primary teeth	75
D2934	Prefabricated esthetic coated stainless steel, primary teeth	75
D2940	Sedative filling	No Charge
D2950	Core build-up including pins	50
D2951	Pin retention in addition to restoration, per tooth	50
D2952/2954	Post and core in addition to crown	50
OTHER RESTORATIVE SERVICES		
D2960	Labial veneer - resin laminate, chairside	100
D2975	Coping	50
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
D3310/3346	Root canal therapy, anterior	100
D3320/3347	Root canal therapy, bicuspid	150
D3330/3348	Root canal therapy, molar	200

ADA CODE	PROCEDURE	MEMBER PAYS
ENDODONTICS (Cont.)		
D3351	Apexification/recalcification – initial visit	No Charge
D3410	Apicoectomy, anterior	130
D3421	Apicoectomy, bicuspid, first root	130
D3425	Apicoectomy, molar, first root	130
D3426	Apicoectomy, each additional root	65
D3430	Retrograde filling, per root	90
PERIODONTICS		
D4210	Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quad	100
D4211	Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quad	50
D4260	Osseous surgery, 4+ contiguous/bounded teeth, per quad	200
D4261	Osseous surgery, 1-3 contiguous/bounded teeth, per quad	100
D4341	Periodontal scaling and root planing, 4+ teeth, per quad	60
D4342	Periodontal scaling and root planing, 1-3 teeth, per quad	30
D4355	Full mouth debridement	45
D4381	Localized delivery of antimicrobial agents, per tooth	40
D4910	Perio maintenance	50
PROSTHODONTICS, REMOVABLE		
D5110/5120	Complete upper or lower denture	250
D5211/5212	Partial denture, resin base, upper or lower	200
D5213/5214	Partial denture, cast metal framework, upper or lower	250
D5410/5411	Adjust complete denture, upper or lower	No Charge
D5421/5422	Adjust partial denture, upper or lower	No Charge
D5510	Repair broken complete denture base	20
D5520	Replace missing or broken teeth, complete denture, per tooth	15
D5610	Repair resin partial denture base	No Charge
D5620	Repair cast framework	10
D5630	Repair or replace broken clasp	10
D5640	Replace broken teeth, partial denture, per tooth	10
D5650/5660	Add tooth or clasp to existing partial denture	10
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	95
D5760/5761	Reline partial upper or lower denture, lab	95
D5850/5851	Tissue conditioning, upper or lower	20
PROSTHODONTICS, FIXED		
D6211	Pontic, cast predominantly base metal	200
D6241	Pontic, porcelain fused to predominantly base metal	250
D6545	Retainer, cast metal for resin bonded fixed prosthesis	100
D6751	Crown, porcelain fused to predominantly base metal	250
D6791	Crown, full cast predominantly base metal	200
D6930	Recement fixed partial denture	No Charge
ORAL SURGERY		
D7140	Extraction, erupted tooth or exposed root	10
D7210	Surgical removal of erupted tooth	30
D7220	Removal of impacted tooth, soft tissue	70
D7230	Removal of impacted tooth, partially bony	90
D7240	Removal of impacted tooth, completely bony	120
D7510	Incision and drainage of abscess–intraoral soft tissue	No Charge
D7511	Incision and drainage of abscess–intraoral soft tissue, complicated	20
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative treatment, emergency	20
D9210	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	40

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. All procedures exclusive of noble and high noble metal (gold). Some procedures may be available in selected offices only. Copayment is due at time services are rendered.

This benefit summary is intended to help you compare coverage, benefits, and limitations and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact Golden West. This comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available at www.goldenwestdental.com. The Evidence of Coverage (EOC) should be consulted for a detailed description of benefits, limitations, exclusions, and the exact terms and conditions of your coverage. You have a right to review the EOC prior to enrollment. To obtain a copy of the EOC, please call (800) 995-4124. If you need further assistance, please contact the Department of Managed Health Care at (888) HMO-2219.

BENEFIT DESCRIPTION	COPAYMENTS	LIMITATIONS/EXCLUSIONS
Annual Deductibles	There is no annual deductible.	
Calendar Year Maximums	There are no calendar year maximums on treatment provided by a network general dentist.	
Lifetime Maximums	There are no lifetime maximums on treatment provided by a network general dentist.	
Professional Services:		
Oral exams	\$0	Once every six (6) months.
Prophylaxis (cleaning)	\$0	Once every six (6) months.
Bitewing x-rays	\$0	Four (4) films in six (6) months.
Full mouth x-rays	\$0	Once every two (2) years for insureds age 12 and over.
Fluoride (child)	\$0	Limited to dependent children up to age 18.
Sealants	\$20 per tooth	Allowed in permanent first and second molars to age 16.
Amalgam fillings (primary or permanent teeth)	\$8-\$32	Treatment of rampant caries is limited to the first seven (7) most severely decayed primary teeth. Replacement fillings allowed after 24 months from initial placement. Benefit for resin fillings on anterior primary teeth is based on the corresponding amalgam benefit.
Resin fillings, anterior (front) teeth	\$25-\$100	
Crowns, single restoration	\$150-\$250	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. Deciduous teeth limited to stainless steel. Must be more than five (5) years old for replacement coverage.
Root Canal Therapy	\$100-\$200	Teeth with poor prognosis are not covered for endodontic treatment.
Apicoectomy (first root)	\$130	
Osseous surgery	\$100-\$200	Limited to four (4) quadrants per lifetime.
Scaling and Root Planing	\$30-\$60	Limited to four (4) quadrants every twenty-four (24) months.
Full Mouth Dentures	\$250	Must be more than five (5) years old for replacement coverage. Personalized or specialized treatment not covered. Initial placement or replacement must be necessitated by the extraction and replacement of one or more natural teeth while covered under this program.
Partial Dentures	\$200-\$250	
Fixed bridge	\$100-\$250 per unit	A fixed bridge in any posterior quadrant is considered elective when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. In this case, a partial denture would be covered.
Extraction of erupted tooth	\$10-\$30	Extractions for orthodontic purposes are not covered including the extraction of non-pathologic, asymptomatic teeth.
Removal of impacted tooth	\$70-\$120	
Emergency palliative treatment	\$20	
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.