

# California

HumanaDental is pleased to offer Golden West DHMO plans in California. The DHMO plan focuses on maintaining oral health with low or no-cost preventive procedures and includes restorative care at fees considerably lower than those charged by non-participating dentists. A member may see a primary care dentist as often as necessary. To find a dentist, call 1-888-200-5022.

## Summary of services

ADA Code	Procedure	Member pays
<b>Oral exams</b>		
D0120	Periodic oral evaluation	no charge
D0140	Limited oral evaluation	no charge
D0150	Comprehensive oral evaluation, new or established patient.	no charge
<b>X-rays</b>		
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
<b>Cleanings and preventive services</b>		
D1110/1120	Prophylaxis—adult or child	no charge
D1201/1203	Fluoride treatment, child	no charge
D1204/1205	Fluoride treatment, adult	\$ 6.00
D1330	Oral hygiene instruction	no charge
D1351	Sealant (per tooth)	\$ 9.00
<b>Space maintainers*</b>		
D1510/1515	Space maintainer, fixed	\$ 40.00
D1520/1525	Space maintainer, removable	\$ 45.00
<b>Restorations</b>		
D2140	Amalgam, 1 surface, primary or permanent	\$ 7.00
D2150	Amalgam, 2 surfaces, primary or permanent	\$ 14.00
D2160	Amalgam, 3 surfaces, primary or permanent	\$ 21.00
D2161	Amalgam, 4 or more surfaces, primary or permanent	\$ 28.00
D2330	Resin based composite, 1 surface, anterior	\$ 10.00
D2331	Resin based composite, 2 surfaces, anterior	\$ 20.00
D2332	Resin based composite, 3 surfaces, anterior	\$ 30.00
D2335	Resin based composite, 4 or more surfaces/incisal angle, anterior	\$ 40.00

ADA Code	Procedure	Member pays
<b>Crowns*</b>		
D2710	Resin based composite, indirect	\$ 60.00
D2720/2721/2722	Resin with metal	\$ 80.00
D2740	Porcelain/ceramic substrate	\$ 140.00
D2750/2751/2752	Porcelain fused to metal	\$ 150.00
D2750/2751/2752	Porcelain fused to metal (molars)	\$ 250.00
D2780/2781/2782	3/4 cast metal	\$ 140.00
D2790/2791/2792	Full cast metal	\$ 140.00
D2910	Recent inlay, onlay or partial coverage restoration	no charge
D2920	Recent crown	no charge
D2930	Stainless steel, primary teeth	\$ 20.00
D2931	Stainless steel, permanent teeth (to age 19)	\$ 30.00
D2940	Sedative filling	no charge
D2950	Core build-up including pins	\$ 30.00
D2951	Pin retention in addition to restoration, per tooth	\$ 10.00
D2952/2954	Post and core in addition to crown	\$ 30.00
<b>Other restorative services*</b>		
D2960	Labial veneer - resin laminate, chairside	\$ 70.00
<b>Endodontics</b>		
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	\$ 20.00
D3310/3346	Root canal therapy, anterior	\$ 75.00
D3320/3347	Root canal therapy, bicuspid	\$ 125.00
D3330/3348	Root canal therapy, molar	\$ 175.00
D3410	Apicoectomy, anterior	\$ 70.00
D3421	Apicoectomy, bicuspid, first root	\$ 70.00
D3425	Apicoectomy, molar, first root	\$ 70.00
D3426	Apicoectomy, each additional root	\$ 30.00
D3430	Retrograde filling, per root	\$ 70.00
<b>Periodontics</b>		
D4210	Gingivectomy/gingivoplasty, 4+ contiguous/bounded teeth, per quadrant	\$ 70.00
D4211	Gingivectomy/gingivoplasty, 1-3 contiguous/bounded teeth, per quadrant	\$ 35.00
D4260	Osseous surgery, 4+ contiguous/bounded teeth, per quadrant	\$ 160.00
D4261	Osseous surgery, 1-3 contiguous/bounded teeth, per quadrant	\$ 80.00
D4341	Periodontal scaling and root planing, 4+ teeth, per quadrant	\$ 30.00
D4342	Periodontal scaling and root planing, 1-3 teeth, per quadrant	\$ 15.00
D4355	Full mouth debridement	\$ 30.00
D4381	Localized delivery of antimicrobial agents per tooth	\$ 40.00
<b>Prosthodontics, removable*</b>		
D5110/5120	Complete denture, upper or lower	\$ 175.00
D5211/5212	Partial denture, resin base, upper or lower	\$ 130.00
D5213/5214	Partial denture, cast metal framework, upper or lower	\$ 195.00
D5410/5411	Adjust complete denture, upper or lower (first 2 visits)	no charge
D5410/5411	Adjust complete denture, upper or lower (subsequent visits)	\$ 9.00
D5421/5422	Adjust partial denture, upper or lower (first 2 visits)	no charge
D5421/5422	Adjust partial denture, upper or lower (subsequent visits)	\$ 9.00
D5510	Repair broken complete denture base	\$ 15.00
D5520	Replace missing or broken teeth, complete denture, per tooth	\$ 10.00
D5610	Repair resin partial denture base	\$ 15.00
D5620	Repair cast framework	\$ 15.00
D5630	Repair or replace broken clasp	\$ 8.00
D5640	Replace broken teeth, partial denture, per tooth	\$ 10.00
D5650/5660	Add tooth or clasp to existing partial denture	\$ 8.00
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	\$ 50.00
D5760/5761	Reline partial upper or lower denture, lab	\$ 50.00
D5820/5821	Interim partial denture, upper or lower	\$ 40.00
D5850/5851	Tissue conditioning, upper or lower	no charge

ADA Code	Procedure	Member pays
<b>Prosthodontics, fixed*</b>		
D6210/6211/6212	Pontic, cast metal	\$ 140.00
D6240/6241/6242	Pontic, porcelain fused to metal	\$ 150.00
D6545	Retainer, cast metal for resin bonded fixed prosthesis	\$ 80.00
D6720/6721/6722	Crown, resin with metal	\$ 75.00
D6750/6751/6752	Crown, porcelain fused to metal	\$ 150.00
D6750/6751/6752	Crown, porcelain fused to metal (molars)	\$ 250.00
D6790/6791/6792	Crown, full cast metal	\$ 140.00
D6930	Recent fixed partial denture	no charge
D6940	Stress breaker (per unit)	\$ 15.00
D6970/6972	Post and core in addition to fixed partial denture retainer	\$ 30.00
D6973	Core buildup for retainer, including pins	\$ 30.00
<b>Oral surgery</b>		
D7140	Extraction, erupted tooth or exposed root	\$ 8.00
D7210	Surgical removal of erupted tooth	\$ 20.00
D7220	Removal of impacted tooth, soft tissue	\$ 30.00
D7230	Removal of impacted tooth, partially bony	\$ 60.00
D7240	Removal of impacted tooth, completely bony	\$ 70.00
D7310	Alveoloplasty with extractions, per quadrant	\$ 60.00
D7311	Alveoloplasty with extractions, 1-3 teeth, per quadrant	\$ 30.00
D7320	Alveoloplasty, without extractions, per quadrant	\$ 60.00
D7321	Alveoloplasty, without extractions, 1-3 teeth, per quadrant	\$ 30.00
D7471	Removal of lateral exostosis	\$ 40.00
D7960	Frenulectomy, separate procedure	no charge
D7970	Excision of hyperplastic tissue, per arch	\$ 35.00
<b>Adjunctive general services</b>		
D9110	Palliative treatment, emergency	\$ 5.00
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	\$ 30.00
<b>Missed appointments</b>		
	Without 24 hours prior notice	\$ 20.00

\*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.

- › Deductible . . . . . None
- › Calendar year maximum . . . . . There are no calendar year maximums on treatment provided by a network general dentist
- › Lifetime maximum . . . . . There are no lifetime maximums on treatment provided by a network general dentist
- › Outpatient services\* . . . . . Not covered
- › Hospitalization services\* . . . . . Not covered
- › Emergency health coverage\* . . . . . Not covered
- › Ambulance services\* . . . . . Not covered
- › Prescription drug coverage\* . . . . . Not covered
- › Durable medical equipment\* . . . . . Not covered
- › Mental health services\* . . . . . Not covered
- › Residential treatment\* . . . . . Not covered
- › Chemical dependency services\* . . . . . Not covered
- › Home health services\* . . . . . Not covered
- › Custodial care and skilled nursing facilities\* . . . . . Not covered

\* Golden West is required by regulation to provide this information. Golden West provides dental, orthodontic, and vision benefits only.

**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.
- › Payment is due at time services are rendered.
- › Out-of-area emergency reimbursement is limited to \$50.00 per calendar year.
- › Benefits for services performed by a participating specialist are limited to \$1,000 per plan year, with a \$2,000 lifetime maximum.

# Orthodontia

## Principal benefits and coverage copayment schedule

## Member pays

• Initial examination . . . . .	no charge
• Diagnostic work-up Includes consultation, study models, and diagnosis on cases where treatment is prescribed. Payable only if patient does not proceed with treatment. . . . .	\$ 100.00
• Full upper and lower banded case—children to age 19 . . . . .	\$ 1,795.00
• Full upper and lower banded case—adult* . . . . .	\$ 1,795.00
• Limited upper and lower banded case (single arch) . . . . .	\$ 1,025.00
• Minor tooth movement . . . . .	\$ 590.00
• Retainer visits and care for six months following completion of 24-month treatment period (Includes cost of retainer appliances.):	
– Full banded case . . . . .	\$ 200.00
– Limited banded case (single arch) . . . . .	\$ 100.00
– Minor tooth movement. . . . .	\$ 100.00
• Retainer visits after initial six-month period (per visit) . . . . .	\$ 15.00
• Broken appointments (without 24 hour notice) . . . . .	\$ 10.00

\* Some Golden West orthodontic offices limit their practice to children.

Please refer to your Golden West network directory for information on which offices accept adult cases.

## Principal exclusions and limitation on benefits

1. Treatment must be provided by a current member of the Golden West Orthodontic panel.
2. Plan benefits include 24 months of standard orthodontic treatment and an additional six months of retention.  
Treatment extending beyond these time periods will be subject to additional charges.
3. Treatment in progress at inception of eligibility is not covered.
4. Once an orthodontic treatment plan has begun, you may not change orthodontic providers.
5. Subscriber and his/her eligible dependent must remain on the plan during the period of time subscriber or dependent is undergoing orthodontic treatment. Termination will result in usual and customary charges for completion of treatment.
6. The following are not considered covered charges under this orthodontic plan:
  - Repair or replacement of lost or broken appliances.
  - Retreatment of orthodontic cases.
  - Changes in treatment necessitated by an accident.
  - Additional charges incurred due to patient neglect or non-compliance with prescribed course of treatment.
  - Maxillofacial surgery, orthognathic surgery, oral surgery for orthodontic purposes (including extractions), micrognathia, macroglossia, cleft palate, myofunctional therapy, speech therapy, treatment of TMJ.
  - X-rays and photographs required for the diagnostic workup.
  - Phase I orthodontic treatment (prior to full mouth banding).

**Any procedure not listed is available on a fee-for-service basis.**

**Orthodontic treatment must be provided by one of the plan's contracted orthodontists.**



Underwritten by Golden West Dental and Vision

This disclosure is only a summary of the dental plan. The dental plan contract and evidence of coverage must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract and evidence of coverage is available on request for examination at the administrative office of Golden West Dental & Vision.

## California

Procedure	Member pays
Visual Analysis (eye exam, including glaucoma testing)	\$ 39.00
<b>Contact lenses (soft)</b>	
<b>Daily Wear</b>	
	<b>cost per lens</b>
Regular Soft	\$ 40.00
Tinted	\$ 45.00
Toric	\$ 70.00
Tinted Toric	\$ 80.00
Custom Toric	\$ 105.00
Aphakic (Post Cataract)	\$ 80.00
Opaque	\$ 65.00
Toric Opaque	\$ 95.00
Bifocal	\$ 100.00
Super Thin	\$ 40.00
<b>Extended Wear</b>	
Regular Soft	\$ 40.00
Tinted	\$ 45.00
Toric	\$ 85.00
Aphakic (Post Cataract)	\$ 90.00
Disposable & Frequent Replacement	10% Discount*
<b>Contact lenses (rigid)</b>	
Hard Lens (P.M.M.A.)	\$ 30.00
Gas Permeable (Daily Wear)	\$ 45.00
Gas Permeable (Extended Wear)	\$ 60.00
Bifocal	\$ 140.00
Toric	\$ 70.00
<b>Complete fitting and three-month follow-up, carekit, and training for contact lenses</b>	
<b>Daily Wear</b>	
Regular Soft, Tinted, Thin, or Hard	\$ 45.00
Disposable & Frequent Replacement	\$ 45.00
<b>All Others</b>	
Toric, Extended Wear, Bifocal, Gas Permeable, Monovision, or Aphakic (Post Cataract)	\$ 112.00
<b>Frames and lenses</b>	
Lenses (All sizes)	25% discount*
Frames (All sizes)	25% discount*
Eyeglass Case (with purchase of eyeglasses)	no charge
Eyeglass Adjustments (with purchase of eyeglasses)	no charge
Sunglasses	25% discount*

\*Not to be combined with any other offer.

### Limitations and exclusions

1. Medical Eye services will be excluded from optometry services.
2. Any procedure not listed on copayment schedule may be available at the Optometrist's Usual and Customary Fees.
3. There will be a charge for broken appointments without notification according to the policy of the optometry office.
4. Follow-up care for contact lenses shall be limited to a period of time not to exceed three (3) months. Additional visits are subject to an office visit charge.
5. Dispensing or prescribing of drugs.
6. Procedures or services determined by the Plan to be special or unusual including, but not limited to, orthoptics, vision training, and subnormal vision aids.
7. Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability Laws. Services which are provided without cost to the member by any municipality, county, or other political subdivision.
8. In the event that patient desires to be hospitalized for any ocular procedure, the cost will be borne by the patient.
9. Treatment required for conditions resulting from major disaster or epidemic or military-serviceconnected conditions.
10. Any experimental procedures.
11. 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. Payment is due at time services are rendered.

