UDC Dental California, Inc.
400 Capitol Mall, 22nd Floor
Sacramento, California 95814
800-443-2995

SECURE CHOICE COPAYMENT SCHEDULE

Benefits provided by: UDC Dental California, Inc.
400 Capitol Mall, 22nd Floor
Sacramento, California 95814
800-443-2995

1. PLAN DENTIST SERVICES (subject to limitations and exclusions listed in the Individual Dental Service Agreement and Combined Evidence of Coverage and Disclosure Form):

This Copayment Schedule provides a complete list of dental services covered under the Plan. These dental services are covered only when provided by Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by this Plan.

Members are covered for the dental services and procedures listed below when they are necessary for dental health in accordance with professionally recognized standards of practice, subject to any applicable limitations and exclusions. Please see the Individual Dental Service Agreement and Combined Evidence of Coverage and Disclosure Form for a complete list of the exclusions and limitations that are applicable to all dental services.

Member will be responsible for paying the amount listed in the "Member Copayment" column, plus any additional laboratory ("lab") fees for certain dental services. Payment may be due at the time the service is received or in accordance with selected Plan Dentist's billing procedures. Lab fees may apply to asterisked (*) services. For such a service, the lab fee is that Plan Dentist's normal retail lab fee for that service.

To fully understand the benefits, exclusions and limitations of this plan, a Member should consult the Individual Dental Service Agreement and the Combined Evidence of Coverage and Disclosure Form to determine specific dental coverage.

Except in the case of (i) covered dental Emergency Services, (ii) Urgent Services outside of Service Area and (iii) reimbursable services by a non-Plan Dentist (See section 5.3 under Article Vin the Individual Dental Service Agreement and section 4.2 under Article IV in the Combined Evidence of Coverage and Disclosure Form), payment for all services received from a non-Plan Dentist will be the responsibility of the Member.

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ADA***Service*** Code	Description	Member Copayment
	Diagnostic Dentistry	
D0120	Periodic Oral Evaluation – Established Patient	No Charge
D0140	Limited Oral Evaluation - Problem Focused	20.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	No Charge
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	20.00
D0210	Intraoral - Complete Series (including bitewings)	10.00
D0220	Intraoral - Periapical First Film	No Charge
D0230	Intraoral - Periapical Each Additional Film	No Charge
D0240	Intraoral - Occlusal Film	No Charge
D0250	Extraoral - First Film	No Charge
D0260	Extraoral - Each Additional Film	No Charge
D0270	Bitewing - Single Film	No Charge
D0272	Bitewings - Two Films	No Charge
D0273	Bitewings – Three Films	No Charge
D0274	Bitewings - Four Films	No Charge
D0277	Vertical Bitewings – 7 to 8 Films	10.00
D0330	Panoramic Film	10.00
D0415	Collection of Microorganisms for Culture and Sensitivity	No Charge
D0425	Caries Susceptibility Tests	No Charge
D0460	Pulp Vitality Tests	No Charge
D0470	Diagnostic Casts	No Charge
None	Periodontal probing in the presence of periodontal disease****	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - Adult (once every 6 months)	10.00
D1120	Prophylaxis – Child (once every 6 months)	10.00
None	Additional Prophylaxis****	35.00
D1203	Topical Application of Fluoride - Child	No Charge
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	No Charge
D1310	Nutritional Counseling for Control of Dental Disease	No Charge
D1330	Oral Hygiene Instructions	No Charge
D1351	Sealant - Per Tooth	20.00
D1510*	Space Maintainer - Fixed – Unilateral	85.00
D1515*	Space Maintainer - Fixed - Bilateral	85.00
D1520*	Space Maintainer - Removable - Unilateral	100.00
D1525*	Space Maintainer - Removable - Bilateral	115.00
D1550	Re-cementation of Space Maintainer	25.00
	Restorative Dentistry	
D2140	Amalgam - One Surface, Primary or Permanent	20.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	25.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	35.00
ADA*Service*** Code	**Description**	**Member Copayment**

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Code	Description	Copayment
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	45.00
D2330	Resin-Based Composite - One Surface, Anterior	40.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	50.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	65.00
D2391	Resin-Based Composite – One Surface, Posterior	75.00
D2392	Resin-Based Composite – Two Surfaces, Posterior	90.00
D2393	Resin-Based Composite – Three Surfaces, Posterior	105.00
D2740*	Crown - Porcelain/Ceramic Substrate	280.00
D2750*	Crown - Porcelain Fused to High Noble Metal	280.00
D2751*	Crown - Porcelain Fused to Predominantly Base Metal	280.00
D2752*	Crown - Porcelain Fused to Noble Metal	280.00
D2790*	Crown - Full Cast High Noble Metal	295.00
D2791*	Crown - Full Cast Predominantly Base Metal	295.00
D2792*	Crown - Full Cast Noble Metal	295.00
D2799*	Interim Crown – further treatment or completion of diagnosis necessary prior to final impression	No Charge
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	20.00
D2920	Recement Crown	20.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	75.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	75.00
D2940	Sedative Filling	20.00
D2950	Core Buildup, Including Any Pins	65.00
D2951	Pin Retention - Per Tooth, in Addition to Restoration	20.00
D2952*	Post and Core in Addition to Crown, Indirectly Fabricated	115.00
D2954	Prefabricated Post and Core in Addition to Crown	85.00
D2960	Labial Veneer (Porcelain Laminate) - Chairside	250.00
D2962*	Labial Veneer (Porcelain Laminate) – Laboratory	350.00
D2980*	Crown Repair by Report	30.00
None	Temporary Filling****	25.00

Endodontics

D3110	Pulp Cap - Direct (excluding final restoration)	20.00
D3120	Pulp Cap – Indirect (excluding final restoration)	15.00
D3220	Therapeutic Pulpotomy (excluding final restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	50.00
D3310**	Endodontic Therapy, Anterior Tooth (excluding final restoration)	180.00
D3320**	Endodontic Therapy, Bicuspid Tooth (excluding final restoration)	225.00
D3330**	Endodontic Therapy, Molar (excluding final restoration)	325.00
D3346**	Retreatment Previous Root Canal Therapy - Anterior	295.00
D3347**	Retreatment Previous Root Canal Therapy - Bicuspid	350.00
D3348**	Retreatment Previous Root Canal Therapy - Molar	395.00
D3410	Apicoectomy/Periradicular Surgery - Anterior	240.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	260.00
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	285.00
D3426	Apicoectomy/Periradicular Surgery (each additional root)	110.00

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ADA*** Code	Service*** Description	Member Copayment
D3430	Retrograde Filling – Per root	75.00
D3450	Root Amputation – Per root	150.00
D3920	Hemisection (including any root removal), Not Including Root Canal Therapy	125.00
	Periodontics	
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	175.00
D4211	Gingivectomy or Gingivoplasty - One to ThreeContiguous Teeth or Tooth Bounded Spaces Per Quadrant	85.00
D4260	Osseous Surgery (including flap entry and closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	395.00
D4261	Osseous Surgery (including flap entry and closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	290.00
D4322	Splint – Intra-coronal; natural teeth or prosthetic crowns	150.00
D4323	Splint – Extra-coronal; natural teeth or prosthetic crowns	125.00
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	90.00
D4342	Periodontal Scaling and Root Planing - One to Three Teeth Per Quadrant	55.00
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation and Diagnosis	65.00
D4910	Periodontal Maintenance	55.00
None	Periodontal Hygiene Instruction****	No Charge
	Removable Prosthodontics	
D5110*	Complete Denture – Maxillary	425.00
D5120*	Complete Denture - Mandibular	425.00
D5130*	Immediate Denture – Maxillary	475.00
D5140*	Immediate Denture - Mandibular	475.00
D5211*	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	450.00
D5212*	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	450.00
D5213*	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	495.00
D5214*	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	495.00
D5410	Adjust Complete Denture - Maxillary	30.00
D5411	Adjust Complete Denture - Mandibular	30.00
D5421	Adjust Partial Denture – Maxillary	30.00
D5422	Adjust Partial Denture - Mandibular	30.00
D5510*	Repair Broken Complete Denture Base	60.00
D5610*	Repair Resin Denture Base	70.00
D5620*	Repair Cast Framework	70.00
D5630*	Repair or Replace Broken Clasp	90.00
D5640*	Replace Broken Teeth - Per Tooth	60.00

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ADA*** Code	Service*** Description	Member Copayment
D5650*	Add Tooth to Existing Partial Denture	80.00
D5730	Reline Complete Maxillary Denture (chairside)	135.00
D5731	Reline Complete Mandibular Denture (chairside)	135.00
D5740	Reline Maxillary Partial Denture (chairside)	125.00
D5741	Reline Mandibular Partial Denture (chairside)	125.00
D5750*	Reline Complete Maxillary Denture (laboratory)	150.00
D5751*	Reline Complete Mandibular Denture (laboratory)	150.00
D5760*	Reline Maxillary Partial Denture (laboratory)	150.00
D5761*	Reline Mandibular Partial Denture (laboratory)	150.00
D5850	Tissue Conditioning, Maxillary	50.00
D5851	Tissue Conditioning, Mandibular	50.00
	Fixed Prosthodontics	
D6210*	Pontic - Cast High Noble Metal	340.00
D6211*	Pontic - Cast Predominantly Base Metal	340.00
D6212*	Pontic - Cast Noble Metal	340.00
D6240*	Pontic - Porcelain Fused to High Noble Metal	340.00
D6241*	Pontic - Porcelain Fused to Predominantly Base Metal	340.00
D6242*	Pontic - Porcelain Fused to Noble Metal	340.00
D6721*	Crown – Resin with Predominately Base Metal	340.00
D6750*	Crown - Porcelain Fused to High Noble Metal	340.00
D6751*	Crown - Porcelain Fused to Predominantly Base Metal	340.00
D6752*	Crown - Porcelain Fused to Noble Metal	340.00
D6790*	Crown - Full Cast High Noble Metal	340.00
D6791*	Crown - Full Cast Predominantly Base Metal	340.00
D6792*	Crown - Full Cast Noble Metal	340.00
D6930	Recement Fixed Partial Denture	45.00
D6940	Stress Breaker	125.00
D6980*	Fixed Partial Denture Repair by Report	50.00
	Oral Surgery	
D7111	Extraction, Coronal Remnants – deciduous tooth	20.00
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)	20.00
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated	70.00
D7220	Removal of Impacted Tooth - Soft Tissue	85.00
D7230	Removal of Impacted Tooth - Partial Bony	100.00
D7240	Removal of Impacted Tooth - Complete Bony	155.00
D7241	Removal of Impacted Tooth - Complete Bony, with Unusual Surgical Complications	195.00
D7250	Surgical Removal of Residual Roots (cutting procedure)	65.00
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	145.00
D7280	Surgical Access of an Unerupted Tooth	195.00
D7310	Alveoloplasty in Conjunction With Extractions - Four or More Teeth or Tooth Spaces Per Quadrant	75.00

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ADA*** Code	Service*** Description	Member Copayment
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces Per Quadrant	135.00
D7471	Removal of Lateral Exotosis (maxilla or mandible)	285.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	65.00
D7960	Frenulectomy – Also Known as Frenectomy or Frenotomy - Separate Procedure Not Incidental To Another	180.00
	Other Services	
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	No Charge
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	15.00
D9241	Intravenous Conscious Sedation/Analgesia – First 30 minutes	160.00
D9310	Consultation – Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	25.00
D9440	Office Visit – After Regularly Scheduled Hours	30.00
D9940*	Occlusal Guard, by report	90.00
D9972	External Bleaching, Per Arch	135.00
None	External Bleaching, Both Arches****	250.00
	Orthodontics	
None	Diagnostic Workup with Radiographs/Model****	175.00
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	900.00
D8040	Limited Orthodontic Treatment of the Adult Dentition	1000.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	1695.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	1895.00
D8660	Pre-Orthodontic Treatment Visit	35.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	95.00
None	Adjusting Retainer, by Report****	No Charge
None	Elastics, by Report****	No Charge
None	Final Orthodontics Records, by Report****	125.00
None	Reattached Brackets and Bands (Limited 3 Times)****	7.00
None	Replace Broken Ligature Wires (Limit 3 Times)****	5.00
None	Premium Transparent Brackets, Per Arch****	200.00

2. PLAN SPECIALIST SERVICES (subject to limitations and exclusions listed in the Individual Dental Service Agreement and Combined Evidence of Coverage and Disclosure Form):

If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain such services from a Plan Specialist. No referral from Member's selected Plan Dentist is needed. The following Copayment schedule applies to covered services when they are provided by a Plan Specialist. Dental services that do not appear on this list are not covered by the Plan. If Member receives a service listed on the schedule, he or she will be responsible for paying the amount in the "Member Copayment" column, plus any additional laboratory ("lab") fees for certain dental services. Payment may be due at the time the service is received or in accordance with the Plan Specialist's billing

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procedures. Lab fees may apply to asterisked (*) services. For such a service, the lab fee is that Plan Dentist's normal retail lab fee for that service.

Members are covered for the dental services and procedures listed below when they are necessary for dental health in accordance with professionally recognized standards of practice, subject to any applicable limitations and exclusions. Please see the Individual Dental Service Agreement and Combined Evidence of Coverage and Disclosure Form for a complete list of the exclusions and limitations that are applicable to all dental services.

To fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with the Plan Specialist prior to treatment. Availability of specific types of specialty services from Plan Specialists depends on which types of dentists are Plan Specialists. Plan does not guarantee that any specific dentist, or any specific type of dentist, will be a Plan Specialist. Types of dentists who are Plan Specialists may vary from time to time in different parts of the Service Area.

Except in the case of (i) covered dental Emergency Services, (ii) Urgent Services outside of Service Area and (iii) reimbursable services by a non-Plan Dentist (See section 5.3 under Article V in the Individual Dental Service Agreement and section 4.2 under Article IV in the Combined Evidence of Coverage and Disclosure Form), payment for all services received from a non-Plan Dentist will be the responsibility of the Member.

ADA*** Code	Service*** Description	Member Copayment
	Diagnostic Dentistry	
D0140	Limited Oral Evaluation - Problem Focused	20.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	No Charge
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	20.00
D0210	Intraoral - Complete Series (including bitewings)	10.00
D0220	Intraoral - Periapical First Film	No Charge
D0230	Intraoral - Periapical Each Additional Film	No Charge
D0240	Intraoral - Occlusal Film	No Charge
D0250	Extraoral - First Film	No Charge
D0260	Extraoral - Each Additional Film	No Charge
D0330	Panoramic Film	10.00
D0415	Collection of Microorganisms for Culture and Sensitivity	No Charge
D0425	Caries Susceptibility Tests	No Charge
D0460	Pulp Vitality Tests	No Charge
D0470	Diagnostic Casts	No Charge
None	Periodontal probing in the presence of periodontal disease****	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - Adult (once every 6 months)	10.00
D1120	Prophylaxis – Child (once every 6 months)	10.00
None	Additional Prophylaxis****	35.00
D1203	Topical Application of Fluoride - Child	No Charge

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ADA Code	***Service*** Description	Member Copayment
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	No Charge
D1351	Sealant - Per Tooth	20.00
D1510*	Space Maintainer - Fixed – Unilateral	85.00
D1515*	Space Maintainer - Fixed - Bilateral	85.00
D1520*	Space Maintainer - Removable - Unilateral	100.00
D1525*	Space Maintainer - Removable - Bilateral	115.00
D1550	Re-cementation of Space Maintainer	25.00
	Restorative Dentistry	
D2140	Amalgam - One Surface, Primary or Permanent	20.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	25.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	35.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	45.00
D2330	Resin-Based Composite - One Surface, Anterior	40.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	50.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	65.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	75.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	75.00
D2940	Sedative Filling	20.00
	Endodontics	
D3220	Therapeutic Pulpotomy (excluding final restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	50.00
D3310**	Endodontic Therapy, Anterior Tooth (excluding final restoration)	180.00
D3320**	Endodontic Therapy, Bicuspid Tooth (excluding final restoration)	225.00
D3330**	Endodontic Therapy, Molar (excluding final restoration)	325.00
D3346**	Retreatment Previous Root Canal Therapy - Anterior	295.00
D3347**	Retreatment Previous Root Canal Therapy - Bicuspid	350.00
D3348**	Retreatment Previous Root Canal Therapy - Molar	395.00
D3410	Apicoectomy/Periradicular Surgery - Anterior	240.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	260.00
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	285.00
D3426	Apicoectomy/Periradicular Surgery (each additional root)	110.00
D3430	Retrograde Filling – Per root	75.00
D3450	Root Amputation – Per root	150.00
D3920	Hemisection (including any root removal), Not Including Root Canal Therapy	125.00
	Periodontics	
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	175.00
D4211	Gingivectomy or Gingivoplasty - One to ThreeContiguous Teeth or Tooth Bounded Spaces Per Quadrant	85.00

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D4260	Osseous Surgery (including flap entry and closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	395.00
D4261	Osseous Surgery (including flap entry and closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	290.00
D4322	Splint – Intra-coronal; natural teeth or prosthetic crowns	150.00
D4323	Splint – Extra-coronal; natural teeth or prosthetic crowns	125.00
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	90.00
D4342	Periodontal Scaling and Root Planing - One to Three Teeth Per Quadrant	55.00
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation and Diagnosis	65.00
D4910	Periodontal Maintenance	55.00
None	Periodontal Hygiene Instruction****	No Charge
	Removable Prosthodontics	
D5850	Tissue Conditioning, Maxillary	50.00
D5851	Tissue Conditioning, Mandibular	50.00
	Oral Surgery	
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated	70.00
D7220	Removal of Impacted Tooth - Soft Tissue	85.00
D7230	Removal of Impacted Tooth - Partial Bony	100.00
D7240	Removal of Impacted Tooth - Complete Bony	155.00
D7241	Removal of Impacted Tooth - Complete Bony, with Unusual Surgical Complications	195.00
D7250	Surgical Removal of Residual Roots (cutting procedure)	65.00
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	145.00
D7280	Surgical Access of an Unerupted Tooth	195.00
D7310	Alveoloplasty in Conjunction With Extractions - Four or More Teeth or Tooth Spaces Per Quadrant	75.00
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces Per Quadrant	135.00
D7471	Removal of Lateral Exotosis (maxilla or mandible)	285.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	65.00
D7960	Frenulectomy – Also Known as Frenectomy or Frenotomy - Separate Procedure Not Incidental To Another	180.00
	Other Services	
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	No Charge
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	15.00
D9241	Intravenous Conscious Sedation/Analgesia – First 30 minutes	160.00
D9310	Consultation – Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	25.00

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	Orthodontics	
None	Diagnostic Workup with Radiographs/Model****	175.00
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	900.00
D8040	Limited Orthodontic Treatment of the Adult Dentition	1000.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	1695.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	1895.00
D8660	Pre-Orthodontic Treatment Visit	35.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	95.00
None	Adjusting Retainer, by Report****	No Charge
None	Elastics, by Report****	No Charge
None	Final Orthodontics Records, by Report****	125.00
None	Reattached Brackets and Bands (Limited 3 Times)****	7.00
None	Replace Broken Ligature Wires (Limit 3 Times)****	5.00
None	Premium Transparent Brackets, Per Arch****	200.00

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