California DENTAL
A DENTAL HEALTH PLAN

THE *NO* PROBLEM PLAN!

- ***No*** *Deductibles!*
- ***No*** *Claim Forms!*
- ***No*** *Annual Maximums!*
- ***No*** *Limitations on Most Pre-Existing Conditions!*
- ***No*** *Waiting Periods to See a Dentist!*

SEE YOUR SAVINGS!

Compare your costs with **California Dental Network's** INDIVIDUAL DENTAL PLAN 595 to average dental fees:

Sample Treatment Plan	Avg. Fee*	With Plan 595	Your Savings
Exams	$88.00	No Charge	$88.00
Cleanings	$93.00	No Charge	$93.00
Full Mouth X-Rays	$136.00	No Charge	$136.00
Filling, 1 surface	$142.00	$4.00	$138.00
Root Canal, single	$762.00	$80.00	$682.00
Crown, PFM	$1152.00	$156.00	$996.00
	$2,373.00	$240.00	$2,133.00

*2012 National Dental Advisory Service for 92653

AFFORDABLE RATES!

	Monthly Checking	Monthly Coupons	Annual Rates
Single	$18.95	$20.95	$227.40
Couple	$28.95	$30.95	$347.40
Family	$39.95	$41.95	$479.40

Plus one-time non-refundable enrollment fee
Single $10, Couple $15, Family $20

SPECIALTY COVERAGE!

Not all general dentists are capable of performing each of the services listed herein and, based upon the member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such cases, the general dentist will refer the member to a dental specialist. The plan will cover 30% of the specialist's fees during the first year of enrollment and 50% thereafter, for up to $1,000 in services per year.

Summary of INDIVIDUAL DENTAL PLAN 595 Benefits and Copayments

*The following dental services are covered benefits for the specified copayment, **only** when provided by a participating **California Dental Network** general dentist, which may be found online at **www.caldental.net***

I. PREVENTIVE SERVICES

	Your Copayment
Office visit	No Charge
Oral examination	No Charge
Intraoral x-rays, complete series	No Charge
Bitewing x-rays, single film	No Charge
Panoramic x-ray	No Charge
Prophylaxis (teeth cleaning)	No Charge
Topical fluoride (child)	No Charge
Oral hygiene instruction	No Charge

II. ROUTINE SERVICES

Restorations	Your Copayment
Amalgam, one surface	$4.00
Amalgam, two surfaces	$5.00
Amalgam, three surfaces	$6.00
Resin, up to three surfaces	$14.00
Temporary sedative filling	$5.00

Oral Surgery	
Extraction, single tooth	$10.00
Surgical removal of erupted tooth	$30.00
Removal of impacted tooth, soft tissue	$40.00
Removal of impacted tooth, partially bony	$50.00
Surgical incision with drainage of abscess, intraoral soft tissue	$14.00

Endodontics	
Pulp cap, direct	$5.00
Pulp cap, indirect	$12.00
Therapeutic pulpotomy	$12.00
Root canal, anterior	$80.00
Root canal, bicuspid	$100.00
Root canal, molar	$140.00

Periodontics	
Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	$100.00
Scaling & root planning, per quadrant	$40.00

* MEMBER IS RESPONSIBLE FOR COPAYMENT PLUS ACTUAL LAB COST OF GOLD.

III. MAJOR SERVICES

Crowns	Your Copayment
Resin with metal*	$156.00
Porcelain fused to high noble metal* (not for molars)	$156.00
Porcelain fused to high noble metal* (for molars)	$236.00
Full cast high noble metal*	$142.00
3/4 cast metallic*	$142.00
Prefabricated stainless steel, permanent tooth	$17.00

Dentures	
Complete upper or lower denture	$160.00
Upper or lower partial denture, resin base	$150.00
Upper or lower partial denture, cast metal base with resin saddles	$175.00
Adjust complete denture	No Charge
Repair broken complete denture base	$15.00
Replace missing or broken teeth, complete denture, each tooth	$17.00
Reline complete or partial upper or lower denture, chairside	$20.00
Reline complete or partial upper or lower denture, laboratory	$42.00

IV. ORTHODONTICS

Standard 24-Month Case	
Full-banded, upper and lower, to age 19	$1,695.00
Full-banded, upper and lower, adults	$1,695.00
Banded, upper *or* lower, children & adults	$1,000.00
Consultation	$40.00
Broken appointments without 24-hour notice	$40.00

V. COSMETIC BENEFITS

Tooth colored fillings, one surface, back tooth	$60.00
Bleaching, per arch	$125.00
Labial veneer (porcelain laminate), laboratory	$400.00
Night guards, soft, includes lab fee	$175.00
Bridge abutment porcelain fused to high noble metal	$345.00
Bridge pontic porcelain fused to high noble metal	$350.00

The ratio of premium costs to health services paid, for plan contracts with individuals and groups of 25 or fewer members, during the preceding fiscal year was 50%.

Detach and Return

ENROLLMENT APPLICATION

Please print or type.

Agent #

Social Security No. | Last Name | First | Initial | Birthday / / | Home Phone ( )

Address | City | State | Zip

Dependents to be covered: *Please indicate Preferred Language other than English for Communications with Plan.

Last Name (if different)	First	Birthday	*Language	Last Name (if different)	First	Birthday	*Language
Spouse:		/ /		Child:		/ /	
Child:		/ /		Child:		/ /	
Child:		/ /		Child:		/ /	

Plan 595

Dental Office #

On behalf of the above named individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct.
NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MALPRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM FOR DETAILS.

Applicant's Signature

California DENTAL
P.O. Box 2428
Laguna Hills, CA 92654

Applications are not accepted without proper premium payment. See brochure for details.

Complete reverse side for automatic checking account deduction or credit card payment options.

Availability of Language Assistance Services: If you, or a member of your family, covered by California Dental Network, cannot speak, read or write English well enough to understand information received from California Dental Network, or to communicate with your dentist, dental office, or California Dental Network about your dental coverage and treatment, then you may request free language assistance. Call, mail or fax the plan, or go online at the plan's website.

Disponibilidad de Servicios de Asistencia de Lenguaje: Si usted o un miembro de su familia cubierto por un Plan de California Dental Network no hablen, leen o escriben el Inglés con suficiente aptitud para entender la información recibida del California Dental Network, o para comunicarse con su dentista, oficina dental o con California Dental Network sobre su plan y cobertura dental, entonces usted puede comunicarse, sin costo alguno pro ese servicio. Llame, mande por correo o por fax al plan, o visite el sitio de internet del plan.

AUTHORIZATION AGREEMENT FOR MONTHLY CHECKING ACCOUNT PAYMENTS

Company Name: California Dental Network, Inc.

Company ID Number: 3123/0001

I hereby authorize **CALIFORNIA DENTAL NETWORK, INC.**, hereinafter called COMPANY, to initiate debit/credit entries to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit/credit the same to such account.

Financial Institution:

_____

Transit/ABA No. _____
(First nine numbers from bottom of check)

Account No. _____

This authority is to remain in full force and effect until COMPANY and FINANCIAL INSTITUTION have received written notification from me of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I understand that I may cancel this authorization by providing written notice to the COMPANY at least five business days prior to the payment due date. I further understand that canceling my authorization does not relieve me of the responsibility of paying my account in full.

Date _____

Name(s) _____

_____
(Please print name(s) here and sign below)

AUTHORIZATION AGREEMENT FOR MONTHLY CREDIT CARD PAYMENTS
(Until terminated or withdrawn in writing)

Credit Card Type: *(Please check one)*

Am Ex___ MasterCard____Visa____ Discover____

Credit Card No._____

Expiration Date:_____

Name as it appears on Card:

_____
(Please print name here and sign below)

Signature(s): _____

_____

Who Is Eligible?

You may enroll your spouse and eligible dependents. Eligible dependents include unmarried children to age 26.

It's Easy To Enroll!

To enroll in **California Dental Network's** Individual Dental Plan 595, just follow these easy steps:

1. Select a dental office from our List of Participating Dentists.
2. Complete the attached Enrollment Application, indicating the number of the dental office you have selected you have selected in the box at the bottom left corner of the Application.
3. Include a check, payable to **California Dental Network**, for your monthly premium and the **one -time enrollment fee**.
4. Mail the application and check to ***California Dental Network 23291 Mill Creek Drive, Suite 100, Laguna Hills, CA 92653***. Your payment must be received by the 20th of the month for your coverage to begin on the first day of the following month.

An Enrollment Application is a request for coverage which, if approved by **California Dental Network**, becomes the enrollment form used to issue an identification card and Combined Evidence of Coverage and Disclosure Form. All benefits, limitations and exclusions are stated in full in the Combined Evidence of Coverage and Disclosure Form which is provided when coverage becomes effective. Members will have 30 days from receipt of the Combined Evidence of Coverage and Disclosure Form to cancel their enrollment and receive a full refund of their premiums if they have not utilized the Plan. You may obtain a copy of the Combined Evidence of Coverage and Disclosure Form from our Corporate Office before you enroll.

Out-of-Area Emergency Care is Covered Too!

If an emergency happens and you need care at a location that is more than 50 miles from your **California Dental Network** dental office, **California Dental Network** will reimburse you up to $50 per year for out-of-area emergency treatment.

Limitations Summary

- Prophylaxis (cleaning) is limited to once every six months.
- Bitewing x-rays are limited to one series of four films every 12 months.
- Full mouth x-rays are limited to once every 24 months.
- Periodontal treatments (subgingival curettage and root planing) are limited to one treatment per quadrant in any 12-month period.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case.
- Replacement of partial dentures is limited to once every five years.
- Full upper and/or lower dentures are not to exceed one each in any five-year period.
- Denture relines are limited to one per arch in any 12-month period.

Exclusions Summary

- General anesthesia, analgesia (nitrous oxide), intravenous sedation, or the services of an anesthesiologist.
- Treatment of fractures or dislocations; congenital malformations; malignancies, cysts, or neoplasms; or Temporomandibular Joint Syndrome (TMJ).
- Extractions or x-rays for orthodontic purposes.
- Prescription drugs and over the counter drugs.
- Any services involving implants or experimental procedures.
- Any procedures performed for cosmetic, elective or aesthetic purposes.
- Any procedure to replace or stabilize tooth structure lost by attrition, abrasion, erosion or grinding.

Para recibir una copia de este plan dental en espanol llame a California Dental Network gratis al numero (877) 433-6825.

California DENTAL NETWORK, INC

23291 Mill Creek Drive, Suite 100, Laguna Hills, CA 92653
Phone: (949) 830-1600 Fax: (949) 830-1655 Toll-free: (877) 4DENTAL
www.caldental.net

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California DENTAL

Individual Dental Plan 595

Summary of Plan Benefits and Copayments