***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 de 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 por ese servicio. Llame, mande por correo o por fax al plan, o visite el sitio de internet del plan.


California DENTAL

23291 Mill Creek Drive
Suite 100
Laguna Hills, CA 92653

Phone (949) 830-1600
Toll-Free (877) 4DENTAL
Fax (949) 830-1655

www. caldental.net


## Who is Eligible?

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

## It's Easy to Enroll!

To enroll in **California Dental Network's** ADVANTAGE PLAN 150, 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.
3. Return the Application to your Group Benefits Coordinator.

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

- Fluoride treatment is covered once every 6 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.
- Sealants are covered for Members up to the age of 14 and are limited to permanent first and second molars.
- The Periodontal treatment of scaling 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, except as listed in the schedule of benefits.
- 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

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Rev. 1-6-14

California DENTAL

# ADVANTAGE PLAN 150

## SUMMARY OF PLAN BENEFITS AND COPAYMENTS

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** ADVANTAGE PLAN 150 to average dental fees:

| Sample Treatment Plan | Avg. Fee* | With ADV 150 | 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 | No Charge | $142.00 |
| Root Canal, single | $762.00 | $100.00 | $662.00 |
| Crown, PFM | $1152.00 | $150.00 | $1002.00 |
| | $2,373.00 | $250.00 | $2,123.00 |

*2012 National Dental Advisory Service for 92653

## CHOOSE FROM HUNDREDS OF DENTISTS!

**California Dental Network** offers comprehensive dental benefits through hundreds of independently owned and operated dental offices conveniently located throughout California.

## SPECIALTY COVERAGE!

All general dentists may not be capable of performing each of the services listed herein and, based upon a Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such a case, the general dentist will refer the Member to a **California Dental Network** participating dental specialist. Your costs for the services of a dental specialist may vary, based upon the coverage option selected by your group.

# Summary of Benefits and Copayments
# Advantage Plan 150

*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 | No Charge |
| Amalgam, two surfaces | No Charge |
| Amalgam, three surfaces | No Charge |
| Resin, one surface anterior | $10.00 |
| Resin, two surface anterior | $15.00 |

| Oral Surgery | |
|---|---|
| Extraction, single tooth | No Charge |
| Surgical removal of erupted tooth | $30.00 |
| Removal of impacted tooth, soft tissue | $60.00 |
| Removal of impacted tooth, partially bony | $125.00 |
| Surgical incision with drainage of abscess, intraoral soft tissue | $60.00 |

| Endodontics | |
|---|---|
| Pulp cap, direct | No Charge |
| Pulp cap, indirect | No Charge |
| Therapeutic pulpotomy | No Charge |
| Root canal, anterior | $100.00 |
| Root canal, bicuspid | $110.00 |
| Root canal, molar | $235.00 |

| Periodontics | |
|---|---|
| Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant | $100.00 |
| Scaling & root planing, per quadrant | $35.00 |

## III. MAJOR SERVICES

| Crowns | Your Copayment |
|---|---|
| Porcelain fused to base metal (not for molars) | $150.00 |
| Porcelain fused to base metal (for molars) | $225.00 |
| Full cast base metal | $150.00 |
| 3/4 cast metallic | $150.00 |
| Prefabricated stainless steel, permanent tooth | $40.00 |

| Dentures & Prosthodontics | |
|---|---|
| Complete upper or lower denture | $175.00 |
| Upper or lower partial denture, resin base | $225.00 |
| Upper or lower partial denture, cast metal base with resin saddles | $225.00 |
| Adjust complete denture | No Charge |
| Repair broken complete denture base | $15.00 |
| Replace missing or broken teeth, complete denture, each tooth | $15.00 |
| Reline complete or partial upper or lower denture, chairside | $40.00 |
| Reline complete or partial upper or lower denture, laboratory | $40.00 |

**Advantage Plan 150 covers many of the name brand crowns and dentures. See evidence of coverage for details.**

## IV. ORTHODONTICS

| Standard 24-Month Case | |
|---|---|
| Phase one interceptive treatment | $1,150.00 |
| Full-banded, upper and lower, to age 19 | $1,775.00 |
| Full-banded, upper and lower, adults | $1,975.00 |
| Banded, upper *or* lower, children & adults | $1,000.00 |
| Consultation | No Charge |

## V. COSMETIC BENEFITS

| | |
|---|---|
| Tooth colored fillings, one surface, back tooth | $70.00 |
| Bleaching, per arch | $125.00 |
| Labial veneer (porcelain laminate), laboratory | $350.00 |
| Night guards, soft, includes lab fee | $150.00 |

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 65%.

Detach and Return

## ENROLLMENT APPLICATION

**Please print or type.** Group # Eff. Date

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

Address City State Zip *Language

Employer's Name Work Telephone ( )

**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 A150

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 Date