

**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 OR ANNUAL 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(Until terminated or withdrawn in writing)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 children to age 26.

**It's Easy to Enroll!**

To enroll in California Dental Network's Individual Dental Plan 460, 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. Your coverage will be automatically renewed at the same terms and conditions unless CDN notifies you in writing at least thirty (30) calendar days before the end of your coverage term describing any changes in the Premium, coverage or other terms or conditions of your coverage.

**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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-433-6825.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-433-6825。

**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.

California Dental Network complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**California Dental Network**

*A DentaQuest company*

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



**California Dental Network**

*A DentaQuest company*

**Individual Plan 460**

*Summary of Plan Benefits  
and Copayments*

# California Dental Network

A DentaQuest company

## 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 Plan 460 to average dental fees:

Sample Treatment Plan	Avg. Fee*	with Plan 460	Your Savings
Exams	\$83	No Charge	\$83
Cleanings	\$138	No Charge	\$138
Full Mouth x-rays	\$193	No Charge	\$193
Filling, 1 surface	\$216	\$10	\$206
Root Canal, single	\$1,535	\$125	\$1,410
Crown, PFM	\$1,658	\$275	\$1,383
<b>Total</b>	<b>\$3,823</b>	<b>\$410</b>	<b>\$3,413</b>

\*2016 National Dental Advisory Service for 92663

## Affordable Rates

	Monthly Checking	Monthly Coupons	Annual Rates
Single	\$7.95	\$8.95	\$70
Couple	\$11.95	\$12.95	\$110
Family	\$16.95	\$17.95	\$150

Plus one-time non-refundable enrollment fee.

One-time enrollment fee for members making monthly payments: \$20

One-time enrollment fee for members making annual payment: \$10

## 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 California Dental Network participating dental specialist.

## INDIVIDUAL DENTAL PLAN 460

The following is a partial list of dental services that are covered benefits, at the specified copayment, when provided by a participating California Dental Network general dentist. Participating dentists may be found online at [www.caldental.net](http://www.caldental.net).

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

<b>Routine Services</b>	
<b>Restorations</b>	
Amalgam, one surface	<b>\$10</b>
Amalgam, two surfaces	<b>\$15</b>
Amalgam, three surfaces	<b>\$20</b>
Resin, up to three surfaces	<b>\$25</b>
Temporary sedative filling	<b>\$10</b>

<b>Oral Surgery</b>	
Extraction, single tooth	<b>\$25</b>
Surgical removal of erupted tooth	<b>\$45</b>
Removal of impacted tooth, soft tissue	<b>\$60</b>
Removal of impacted tooth, partially bony	<b>\$75</b>
Surgical incision with drainage of abscess, intraoral soft tissue	<b>\$40</b>

<b>Endodontics</b>	
Pulp cap, direct	<b>\$15</b>
Pulp cap, indirect	<b>\$15</b>
Therapeutic pulpotomy	<b>\$25</b>
Root canal, anterior	<b>\$125</b>
Root canal, bicuspid	<b>\$150</b>
Root canal, molar	<b>\$185</b>

<b>Periodontics</b>	
Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	<b>\$150</b>
Scaling & root planing, per quadrant	<b>\$40</b>

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 60%.

Services	Your Copayment
<b>Major</b>	
<b>Crowns</b>	
Resin with metal*	<b>\$175</b>
Porcelain fused to high noble metal (not for molars)*	<b>\$275</b>
Porcelain fused to high noble metal (for molars)*	<b>\$350</b>
Full cast high noble metal*	<b>\$250</b>
3/4 cast metallic*	<b>\$250</b>
Prefabricated stainless steel, permanent tooth	<b>\$50</b>

<b>Dentures &amp; Prosthodontics</b>	
Complete upper or lower denture	<b>\$350</b>
Upper or lower partial denture, resin base	<b>\$300</b>
Upper or lower partial denture, cast metal base with resin saddles	<b>\$350</b>
Adjust denture	<b>\$25</b>
Add tooth to existing partial denture	<b>\$50</b>
Add clasp to existing partial denture	<b>\$50</b>
Adjust complete or partial, upper or lower denture, laboratory	<b>\$100</b>
Porcelain fused to high noble metal* pontic	<b>\$200</b>
Resin with high noble metal* pontic	<b>\$175</b>
Cast high noble metal* pontic	<b>\$200</b>
Recement Bridge	<b>\$25</b>

<b>Orthodontics</b>	
<b>Standard 24-month case</b>	
Full-banded, upper and lower, to age 19	<b>\$1,775</b>
Full-banded, upper and lower, adults	<b>\$1,975</b>
Banded, upper or lower, children & adults	<b>\$1,000</b>

\*Member is responsible for copayment plus actual lab cost for gold.

detach and return

## ENROLLMENT APPLICATION

Please print or type.

Agent Number:

Social Security No.

Last Name

First

Initial

Birthdate

/ /

Home Phone ( )

Address

City

State

Zip

Language\*

E-mail Address

Disabled? Y / N

**Dependents to be covered:**

\*Please indicate Preferred Language other than English for Communications with Plan.

Last Name (if different)

First

Birthdate

Disabled? Y / N

\*Language

Birthdate

Disabled? Y / N

Spouse:

Child:

/ /

Y / N

Child:

Child:

/ /

Y / N

Child:

Child:

/ /

Y / N

**Plan 460**

**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. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM FOR DETAILS.**

Applicant's Signature

Date