

# INDIVIDUAL DENTAL PLAN 460

## SUMMARY OF PLAN BENEFITS AND COPAYMENTS



### WHO IS ELIGIBLE?

You may enroll your spouse and eligible dependents. Eligible dependents include unmarried children to age 19 and full-time students to age 23. A full-time student is defined as taking 12 or more units. Verification is required.

### 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 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, 1971 E. 4th Street, Suite 184, Santa Ana, CA 92705-3917**. We must receive your application and payment 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

- ◆ 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

- ◆ 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 esta plan dental en español llame a California Dental Network gratis a numero (877) 433-6825.





## 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 460 to average dental fees:

Sample Treatment Plan	Avg. Fee*	With Plan 460	Your Savings
Exams.....	\$47.00	No Charge	\$47.00
Cleanings .....	\$65.00	No Charge	\$65.00
Full Mouth X-Rays...	\$86.00	No Charge	\$86.00
Filling, 1 surface .....	\$70.00	\$10.00	\$60.00
Root Canal, single .....	\$404.00	\$125.00	\$279.00
Crown, PFM .....	\$662.00	\$275.00	\$387.00
	\$1,334.00	\$410.00	\$924.00

\*1998 Medicode Fee Analyzer

## AFFORDABLE RATES!

	Monthly Checking	Monthly Coupons	Annual Rates
Single .....	\$7.95	\$8.95	\$70.00
Couple .....	\$11.95	\$12.95	\$110.00
Family .....	\$16.95	\$17.95	\$150.00

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

## 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 who will give the Member a 25% discount from their regular fees.

# Summary of INDIVIDUAL DENTAL PLAN 460 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.

## I. PREVENTIVE SERVICES

	YOUR COPAYMENT
Office visit .....	\$5.00
Oral examination .....	No Charge
Intraoral x-rays, complete series .....	No Charge
Bitewing x-rays, single film .....	No Charge
Panoramic x-ray .....	No Charge
Prophylaxis (cleaning) .....	No Charge
Topical fluoride (child) .....	No Charge
Oral hygiene instruction .....	No Charge

## II. ROUTINE SERVICES

	YOUR COPAYMENT
<b>RESTORATIONS</b>	
Amalgam, one surface .....	\$10.00
Amalgam, two surfaces .....	\$15.00
Amalgam, three surfaces .....	\$20.00
Resin, up to three surfaces .....	\$25.00
<b>ORAL SURGERY</b>	
Extraction, single tooth .....	\$25.00
Root removal .....	\$45.00
Surgical removal of erupted tooth .....	\$45.00
Removal of impacted tooth, soft tissue .....	\$60.00
Removal of impacted tooth, partially bony .....	\$75.00
Surgical removal of residual tooth roots .....	\$45.00
<b>ENDODONTICS</b>	
Pulp cap, direct .....	\$15.00
Pulp cap, indirect .....	\$15.00
Therapeutic pulpotomy .....	\$25.00
Root canal, anterior .....	\$125.00
Root canal, bicuspid .....	\$150.00
Root canal, molar .....	\$185.00

### PERIODONTICS

Gingivectomy or gingivoplasty, per quadrant ...	\$150.00
Surgical gingival curettage, per quadrant .....	\$40.00
Root planing, per quadrant .....	\$40.00

## III. MAJOR SERVICES

	YOUR COPAYMENT
<b>CROWNS</b>	
Resin with metal* .....	\$175.00
Porcelain fused to high noble metal* (not for molars) .....	\$275.00
Porcelain fused to high noble metal* (for molars) .....	\$350.00
Full cast high noble metal* .....	\$250.00
3/4 cast metallic* .....	\$250.00
Prefabricated stainless steel, primary tooth .....	\$50.00
Sedative filling .....	\$10.00

### DENTURES & PROSTHODONTICS

Cast high noble metal* pontic .....	\$200.00
Porcelain fused to high noble metal* pontic .....	\$200.00
Resin with high noble metal* pontic .....	\$175.00
Re-cement bridge .....	\$25.00
Complete upper or lower denture .....	\$350.00
Upper or lower partial denture, resin base .....	\$300.00
Upper or lower partial denture, cast metal base with resin saddles .....	\$350.00
Adjust denture .....	\$25.00
Repair broken complete denture base .....	\$50.00
Replace missing or broken teeth, complete denture, each tooth .....	\$25.00
Add tooth to existing partial denture .....	\$50.00
Add clasp to existing partial denture .....	\$50.00
Reline complete or partial upper or lower denture, chair-side .....	\$65.00
Reline complete or partial upper or lower denture, lab .....	\$100.00

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

## IV. ORTHODONTICS

### STANDARD 24-MONTH CASE

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 .....	\$25.00
Broken appointments without 24-hour notice .....	\$25.00

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 0%.

<p><b>PLAN SELECTION</b></p> <p>Plan # <u>460</u></p> <hr/> <p><b>DENTIST SELECTION</b></p> <p>Dental Office # _____</p> <hr/> <p><b>AGENT INFORMATION</b> (if known)</p> <p>Agent # <u>766</u></p> <hr/> <p>Name _____ Insurance Planning 101</p> <hr/> <p>Phone <u>1-800-664-5433</u></p>	<p align="center"><b>ENROLLMENT APPLICATION</b> Please print or type</p> <hr/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Social Security No.</td> <td style="width: 25%;">Last Name</td> <td style="width: 10%;">First</td> <td style="width: 10%;">Initial</td> <td style="width: 15%;">Birthday</td> <td style="width: 15%;">Home Phone</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td align="center">/ /</td> <td align="center">( )</td> </tr> </table> <hr/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Address</td> <td style="width: 20%;">City</td> <td style="width: 15%;">State</td> <td style="width: 15%;">Zip</td> </tr> </table> <hr/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Employer's Name</td> <td style="width: 30%;">Work Telephone</td> </tr> <tr> <td></td> <td align="center">( )</td> </tr> </table> <hr/> <p><b>Dependents to be covered:</b></p> <p>Spouse: _____ / /      Child: _____ / /</p> <p>Child: _____ / /      Child: _____ / /</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Last Name (if different)</td> <td style="width: 10%;">First</td> <td style="width: 15%;">Birthday</td> <td style="width: 25%;">Last Name (if different)</td> <td style="width: 10%;">First</td> <td style="width: 15%;">Birthday</td> </tr> </table> <p><small>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 FROM FOR DETAILS.</small></p> <hr/> <p>Applicant's Signature _____ Date _____</p>	Social Security No.	Last Name	First	Initial	Birthday	Home Phone					/ /	( )	Address	City	State	Zip	Employer's Name	Work Telephone		( )	Last Name (if different)	First	Birthday	Last Name (if different)	First	Birthday
Social Security No.	Last Name	First	Initial	Birthday	Home Phone																						
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Address	City	State	Zip																								
Employer's Name	Work Telephone																										
	( )																										
Last Name (if different)	First	Birthday	Last Name (if different)	First	Birthday																						

Complete this form if you choose to have your monthly premiums deducted automatically from your checking account. Scroll down for credit card option.

**AUTHORIZATION AGREEMENT FOR PREAUTHORIZED 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.: \_\_\_\_\_ Account No.: \_\_\_\_\_  
(First nine numbers from bottom of check)

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 names here and sign below)

Complete this form if you choose to have your monthly premiums deducted automatically from your credit card.

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

Credit Card Type: (Please check one)    Am Ex \_\_\_\_\_    Mastercard \_\_\_\_\_    Visa \_\_\_\_\_    Discover \_\_\_\_\_

Credit Card No.: \_\_\_\_\_ Name as it appears on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_