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(Until terminated or withdrawn in writing)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 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. 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.

Rev. 4/17

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.
- Implant services covered at the General Dentist only.
- Implants are limited to no more than once for the same tooth position in a five (5) year period.
- Implants and Implant abutments are limited to no more than two (2) each per year.

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; orTemporomandibular 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 595

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 595 to average dental fees:

Sample Treatment Plan	Avg. Fee*	with Plan 595	Your Savings
Exams	$83	No Charge	$83
Cleanings	$138	No Charge	$138
Full Mouth x-rays	$193	No Charge	$193
Filling, 1 surface	$216	$4	$212
Root Canal, single	$1,535	$80	$1,450
Crown, PFM	$1,658	$156	$1,502
Total	**$3,823**	**$240**	**$3,538**

*2016 National Dental Advisory Service for 92663

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.
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 dental specialist (subject to exclusions and limitations). The plan will cover 30% of the specialist's fees on covered, approved, services during the first year of enrollment, and 50% thereafter, for up to $1000 in services per year.

INDIVIDUAL DENTAL PLAN 595

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.

Services	Your Copayment
Preventive	
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
Routine Services	
Restorations	
Amalgam, one surface	$4
Amalgam, two surfaces	$5
Amalgam, three surfaces	$6
Resin, up to three surfaces	$14
Temporary sedative filling	$5
Oral Surgery	
Extraction, single tooth	$10
Surgical removal of erupted tooth	$30
Removal of impacted tooth, soft tissue	$40
Removal of impacted tooth, partially bony	$50
Surgical incision with drainage of abscess, intraoral soft tissue	$14
Endodontics	
Pulp cap, direct	$5
Pulp cap, indirect	$12
Therapeutic pulpotomy	$12
Root canal, anterior	$80
Root canal, bicuspid	$100
Root canal, molar	$140
Periodontics	
Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	$100
Scaling & root planing, per quadrant	$40

Services	Your Copayment
Major	
Crowns	
Porcelain fused to high noble metal (not for molars)*	$156
Porcelain fused to high noble metal (for molars)*	$236
Full cast high noble metal*	$142
Prefabricated stainless steel, permanent tooth	$17
Dentures & Prosthodontics	
Complete upper or lower denture	$160
Upper or lower partial denture, resin base	$150
Upper or lower partial denture, cast metal base with resin saddles	$175
Implants - Services covered at the General Dentist only.	
Surgical placement of implant body, endosteal	$1,500
Prefabricated abutment, includes placement	$450
Abutment supported porcelain/ceramic crown	$1,055
Recement implant/abutment supported crown	$45
Orthodontics	
Standard 24-month case	
Full-banded, upper and lower, to age 19	$1,695
Full-banded, upper and lower, adults	$1,975
Banded, upper or lower, children & adults	$1,000
Cosmetic Benefits	
Tooth colored fillings, one surface, back tooth	$60
Bleaching, per arch	$125
Labial veneer (porcelain laminate), laboratory	$400
Night guards, soft, includes lab fee	$175

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

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%.

detach and return

ENROLLMENT APPLICATION

Please print or type.

Agent Number:

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

Address | City | State | Zip | Language* | Disabled? Y / N

E-mail Address

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

Dependents to be covered:

Last Name (if different) | First | Birthday | *Language | Disabled? Y / N | Last Name (if different) | First | Birthday | *Language | Disabled? Y / N

Spouse: _____ / / _____ Y / N Child: _____ / / _____ Y / N

Child: _____ / / _____ Y / N Child: _____ / / _____ Y / N

Child: _____ / / _____ Y / N Child: _____ / / _____ Y / N

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

Applicant's Signature ***Date***