

CA80 Payment Form

Single Coverage

Annual Fee	\$150.71
Enrollment Fee	\$ 20.00
Amount Enclosed	\$170.71

2-Party Coverage

Annual Fee	\$193.25
Enrollment Fee	\$ 20.00
Amount Enclosed	\$213.25

Family Coverage

Annual Fee	\$265.90
Enrollment Fee	\$ 20.00
Amount Enclosed	\$285.90

Your annual payment must be enclosed with the enrollment form to begin eligibility in this plan.

- I have enclosed a check or money order.
- Please have my payment charged to my credit card.
- Master Card Visa
- American Express Discover

Credit Card Number _____

Expiration Date _____

Signature _____

Please complete both sides of this form and mail with payment to:
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110

Broker # _____

Group #048700



LIBERTY Dental Plan of California

CA80 Individual/Family Plan



Administrative Office
P.O Box 26110
Santa Ana, CA 92799-6110

(888) 703-6999
Fax: (949) 223-0011
www.Libertydentalplan.com

Discover the advantages of "Simply better coverage"™

Dental Benefits should be simple to use for you and your family. Our CA80 plan offers comprehensive dental coverage without claim forms, deductibles or annual maximum limitations.

LIBERTY Dental Plan contracts with quality dental professionals to provide services to you and your eligible dependents at no cost or for low fixed co-payments. We take pride in our relationship with our dental professionals. This relationship enables our members to receive the care they deserve when enrolling in our plans.

Our goal is to provide you with the comprehensive dental benefits you purchase. We pledge to support your choice of LIBERTY Dental Plan by giving you confidence through the excellent customer service you deserve. After all, isn't that what it is all about!

LIBERTY Dental Plan has been providing and administering dental benefits in California for over twenty (20) years. All of our contracted providers have undergone strict credentialing procedures, background checks and office evaluations. In addition, each provider must adhere to strict contractual guidelines. Our Provider Relations Department conducts a Quality Assessment Program which includes ongoing contract management to assure compliance with continuing education, accessibility for members, appropriate diagnosis and treatment planning.

Membership Eligibility: If you reside in our service area, you and your eligible dependents may enroll in this plan. Eligible dependents include your spouse, unmarried dependent children who are under the age of nineteen, unmarried children under the age of twenty-four (24) if they are a full-time student at an accredited college or university, disabled children dependent upon you for support and are not able to support themselves due to physical or mental handicap (you must provide proof of disability or handicap at the time you enroll) and adopted or step-children meeting the above requirements.

Selecting a Dental Provider: You do not need to select a contracted Primary Care Dentist when you enroll in this plan. However, to receive benefits under this plan, you must receive services from a CA80 contracted LIBERTY Dental Plan Dentist. Visit www.libertydentalplan.com to view dental office options.

Appointment Scheduling: Once you are enrolled and eligible under the Plan, you may call the CA80 contracted LIBERTY Dental Plan Dentist of your choice directly to schedule an appointment. Be sure to identify yourself as a member of LIBERTY Dental Plan when you call. Co-payments are due and payable to your provider at the time services are rendered.

Specialty Referral: If your CA80 contracted LIBERTY Dental Plan Dentist encounters a situation requiring the services of a Dental Specialist, he/she will contact LIBERTY Dental Plan to initiate the Specialty Referral process. Specialty services are available based on a separate co-payment schedule. See Schedule of Benefits for full disclosure.

Emergency Dental Care: All contracted LIBERTY Dental Plan offices provide for emergency dental care twenty-four (24) hours per day, seven (7) days per week. If you are more than fifteen (15) miles or thirty (30) minutes from a CA80 contracted LIBERTY Dental Plan Dentist, or you cannot contact a CA80 contracted LIBERTY Dental Plan Dentist or LIBERTY Dental Plan Member Services, simply contact any licensed dentist to receive care. LIBERTY Dental Plan will reimburse you for dental expenses for covered services related to the relief of pain only, up to a maximum of fifty dollars (\$50), less any applicable co-payments.

- No Claim Forms
- No Annual Deductible
- No Annual Maximums



Summary of Benefits

This brochure is only a summary of the dental plan. You will receive a complete Summary of Benefits and Evidence of Coverage with an ID card in the mail after your enrollment has been processed.

DIAGNOSTIC AND PREVENTIVE

Periodic oral examination.....	\$8
Office visit	\$8
X-rays, complete series.....	N/C
Panorex film	N/C
Adult prophylaxis (1 every 6 months)	N/C
Child prophylaxis (1 every 6 months)	N/C
Topical fluoride (1 every six months to age 18).....	N/C
Sealant, per tooth (to age 14).....	\$15

RESTORATIVE

Amalgam filling, 1 surface.....	\$25
Amalgam filling, 2 surface.....	\$32
Amalgam filling, 3 surface.....	\$42
Resin filling, 1 surface, anterior.....	\$38
Resin filling, 1 surface permanent posterior	\$45

CROWN & BRIDGE

Crown, porcelain fused to base metal*	\$280
Crown, full cast base metal*	\$235
Core buildup, includes any pins.....	\$99
Cast post & core in addition to crown*	\$90
Pontic, porcelain fused to base metal*	\$280

* Precious or semi-precious metal may be substituted for non-precious metal at an additional charge equal to its current lab cost.

ENDODONTICS

Pulp capping	\$20
Therapeutic pulpotomy.....	\$40
Root canal, anterior.....	\$150
Root canal, bicuspid	\$190
Root canal, molar.....	\$245
Apicoectomy	\$475

ORAL SURGERY

Simple extraction	\$28
Impaction, soft tissue.....	\$68
Impaction, partial bony.....	\$100
Impaction, complete bony	\$130
Alveoplasty with extraction, per quadrant	\$35

PERIODONTICS

Gingivoplasty/gingivectomy, per quadrant	\$220
Osseous surgery, per quadrant	\$650

Periodontal scaling & root planing, per quadrant.....	\$60
Full mouth debridement	\$50

REMOVABLE PROSTHODONTICS

Complete denture, upper or lower	\$385
Partial denture, resin base.....	\$385
Adjust denture.....	\$22
Replace missing or broken tooth.....	\$35
Reline complete denture, chairside.....	\$60

ADJUNCTIVE SERVICES

Emergency palliative treatment.....	\$15
Local anesthesia	N/C
Office visit, after regular hours	\$20
Broken appointment.....	\$10
Nitrous oxide, first 15 minutes	\$45

ORTHODONTICS

Start-up fees	\$175
Class II & III malocclusion, full upper & lower	\$2,300
Post treatment stabilization, child	\$300

EXCLUSIONS

- Any procedure not specifically listed as a covered benefit.
- Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures and orthodontic appliances.
- Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit.
- Procedures considered experimental, treatment involving implants or pharmacological regimens. (See "Independent Medical Review" on page 6 of the Evidence of Coverage.)
- Oral surgery requiring the setting of bone fractures or bone dislocations.
- Hospitalization is not covered.
- Out-patient services are not covered.
- Ambulance services are not covered
- Durable Medical Equipment is not covered.
- Mental Health Equipment is not covered.
- Chemical Dependency services are not covered.
- Home Health services are not covered.
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist are not covered services.
- Treatment started before the member was eligible or after the member was no longer eligible.
- Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofunctional (e.g. speech therapy), myoskeletal, or temporomandibular joint dysfunctions (e.g. adjustments/correction to the facial bones) unless otherwise covered as an orthodontic benefit.

- Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
- Treatment of malignancies, cyst, or neoplasms.
- Orthodontic treatment prior to member's effective date of coverage.
- Appliances needed to increase vertical dimension or restore occlusion are not covered services.
- Any services performed outside your assigned dental office, unless expressly authorized by LIBERTY Dental Plan or unless as outlined and covered in "Emergency Dental Care" section.

LIMITATIONS

- Prophylaxis are covered once every six consecutive months.
 - Full mouth x-rays are limited to once every 36 consecutive months.
 - Fluoride treatments are covered once every 6 consecutive months.
 - Sealants are covered only on the first and second permanent molars and up to the 14th birthday.
 - Crowns, jackets, inlays and onlays are benefits on the same tooth only once every five years and consistent with professionally recognized standards of dental practice.
 - Replacement of existing full and partial dentures are covered once per arch every 5 years except when they cannot be made functional through reline or repair.
 - Denture relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice.
 - Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.
- ### ORTHODONTIC EXCLUSIONS
- Lost, stolen or broken appliances
 - Extractions for orthodontic purposes (will not apply if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition).
 - Temporomandibular joint syndrome (TMJ) surgical orthodontics.
 - Myofunctional therapy.
 - Treatment of cleft palate, micrognathia, and macroglossia.



CA80 Enrollment Form

First Name: _____

Last Name: _____

SSN: _____ Male Female

Date of Birth: _____

Address: _____

City: _____, CA Zip: _____

Home Phone: () _____

DEPENDENTS

Spouse Name: _____

Date of Birth: _____

1. Child Name: _____

Date of Birth: _____

2. Child Name: _____

Date of Birth: _____

3. Child Name: _____

Date of Birth: _____

4. Child Name: _____

Date of Birth: _____

I understand eligibility will begin on the first day of the month following receipt of this application and payment. However, I understand this application and payment must be received by LIBERTY Dental Plan by the 20th of the month for eligibility to be effective the first day of the following month. If application and payment is received after the 20th day of the month, eligibility will begin the first of the next following month.

Signature _____

Date _____