CA1000 Plan
Individual/Family

Discover simply better coverage

Dental Benefits should be simple to use for you and your family. Our **CA1000 Plan** offers comprehensive dental coverage with **No Claim Forms, No Annual Deductibles** and **No 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 twenty-six (26), disabled children beyond any limiting age that are dependent upon you for support and are not able to support themselves due to physical or mental handicap including blindness or partial blindness (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 **CA1000 Plan** contracted LIBERTY Dental Plan Dentist. To find a dental provider in your area, visit our website at: www.libertydentalplan.com, click on "find a dentist", then select your benefit plan and enter your location information.

Appointment Scheduling: Once you are enrolled and eligible under the Plan, you may call the **CA1000 Plan** 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 **CA1000 Plan** 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 **CA1000 Plan** contracted LIBERTY Dental Plan Dentist, or you cannot contact a **CA1000 Plan** contracted LIBERTY Dental Plan Dentist or LIBERTY Dental Plan Member Services, simply contact any licensed dentist to receive emergency 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 seventy-five dollars ($75), less any applicable co-payments.

LIBERTY DENTAL PLAN ®

Making members shine, one smile at a time™

LIBERTY Dental Plan

File 1751
1801 W. Olympic Blvd.
Pasadena, CA 91199

800.72.SMILE

Cut here and mail in this form

Subscriber Information

Group # 049015

First Name: | Last Name: | **Broker #**

Address: | City: | State: **CA** | Zip Code:

Date of Birth: | SSN: | Primary Phone: | ☐ **Male** ☐ **Female**

Family Information / Dependents

Spouse (First, Last): | Date of Birth:

Child (First, Last): | Date of Birth:

Child (First, Last): | Date of Birth:

Child (First, Last): | Date of Birth:

Child (First, Last): | Date of Birth:

Payment Information (Select One)

☐ Check or Money Order **(pay to LIBERTY Dental Plan)**

☐ Credit Card **(complete portion below)**

Card Type: ☐ **MasterCard** ☐ **Visa** ☐ **American Express** ☐ **Discover**

C. C. #

C. C. Expiration Date: ___ ___ / ___ ___ / ___ ___

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 _____

New Member

☐ **Single: $106.65***

☐ **2-Party: $136.73***

☐ **Family: $188.13***

*Payment is for 12 months of coverage

CA1000 Enrollment Form

Complete Form (with check) and Mail to:

LIBERTY Dental Plan
File 1751
1801 W. Olympic Blvd.
Pasadena, CA 91199

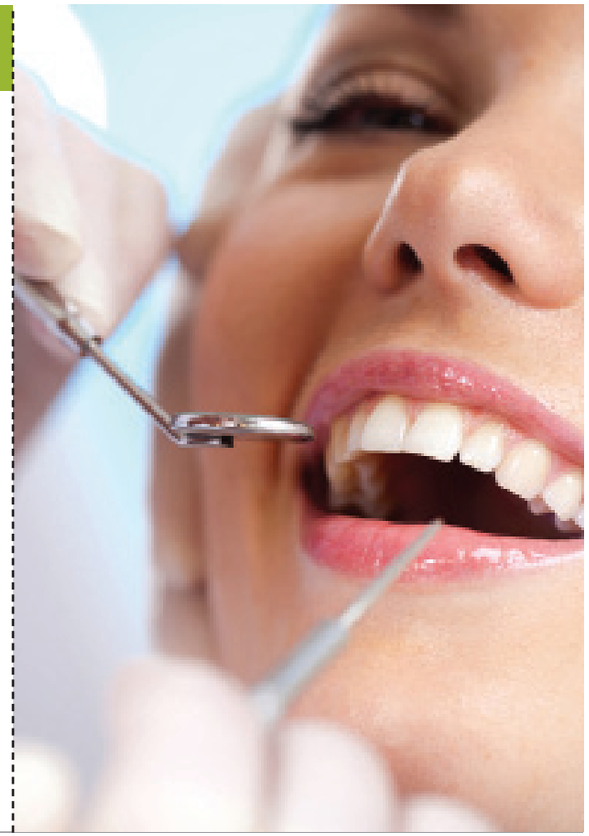
CA1000 Plan Summary of Benefits*

DIAGNOSTIC AND PREVENTIVE		
D0120	Periodic oral examination	$12
D9999	Office visit	$0
D0210	X-rays, complete series	$35
D0330	Panoramic film	$35
D1110	Adult prophylaxis (1 every 6 months)	$28
D1120	Child prophylaxis (1 every 6 months)	$22
D1208	Topical fluoride (1 every six months to age 18)	$7
D1351	Sealant, per tooth (to age 14)	$10
RESTORATIVE		
D2140	Amalgam filling, 1 surface	$35
D2150	Amalgam filling, 2 surfaces	$45
D2160	Amalgam filling, 3 surfaces	$56
D2330	Resin filling, 1 surface, anterior	$45
D2391	Resin filling, 1 surface, posterior	$60
CROWN & BRIDGE		
D2751	Crown, porcelain fused to base metal	$383
D2791	Crown, full cast base metal	$337
D2950	Core buildup, includes any pins	$94
D2952	Post & core in addition to crown	$139
D6241	Pontic, porcelain fused to base metal	$383

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

ENDODONTICS		
D3110	Pulp capping, direct	$30
D3220	Therapeutic pulpotomy	$61
D3310	Root canal, anterior (exculding final restoration)	$244
D3320	Root cana, bicuspid (excluding final resotration)	$293
D3330	Root canal, molar (excluding final restoration)	$387
D3425	Apicoectomy, molar	$210
ORAL SURGERY		
D7140	Simple extraction	$53
D7220	Impaction, soft tissue	$150
D7230	Impaction, partial bony	$175
D7240	Impaction, complete bony	$206
D7311	Alveoplasty with extraction, 1-3 teeth, quadrant	$110
PERIODONTICS		
D4211	Gingivoplasty/gingivectomy, 1-3 teeth per quadrant	$41
D4261	Osseous surgery, 1-3 teeth per quadrant	$531
D4342	Periodontal scaling & root planing, 1-3 teeth/quadrant	$97
D4355	Full mouth debridement	$30
REMOVABLE PROSTHODONTICS		
D5120	Complete denture, lower	$549
D5212	Partial denture, resin base, lower	$347
D5411	Adjust complete denture, lower	$23
D5520	Replace missing or broken tooth, complete denture	$63
D5731	Reline complete lower denture, chairside	$137
ADJUNCTIVE SERVICES		
D9110	Emergency palliative treatment	$30
D9210	Local anesthesia	$0
D9230	Inhalation of nitrous oxide	$45
D9440	Office visit, after regular hours	$70
D9999	Broken appointment (less than 24 hour notice)	$25
ORTHODONTICS		
D9310	Consultation	$0
D8080	Comprehensive orthodontic treatment, child	$2,200
D8680	Orthodontic retention	$300

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



EXCLUSIONS

1. Any procedure not specifically listed as a covered benefit.
2. Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures and orthodontic appliances.
3. 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.
4. Procedures considered experimental, treatment involving implants or pharmacological regimens. (See "Independent Medical Review" on page 6 of the Evidence of Coverage.)
5. Oral surgery requiring the setting of bone fractures or bone dislocations.
6. Hospitalization is not covered.
7. Out-patient services are not covered.
8. Ambulance services are not covered
9. Durable Medical Equipment is not covered.
10. Mental Health Equipment is not covered.
11. Chemical Dependency services are not covered.
12. Home Health services are not covered.
13. General anesthesia, analgesia, intravenous/intramuscular sedation or the services on an anesthesiologist are not covered services.
14. Treatment started before the member was eligible or after the member was no longer eligible.
15. Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofuncional (e.g. speech therapy), myoskelatal, or temporomandibular joint dysfunctions (e.g. adjustments/correction to the facial bones) unless otherwise covered as an orthodontic benefit.
16. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice.
17. Treatment of malignancies, cyst, or neoplasms.
18. Orthodontic treatment prior to member's effective date of coverage.
19. Appliances needed to increase vertical dimension or restore occlusion are not covered services.
20. 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

1. Prophylaxis are covered once every 6 consecutive months.
2. Full mouth x-rays or panoramic films are limited to once every 36 consecutive months.
3. Fluoride treatments are covered once every 6 consecutive months.
4. Sealants are covered only on the first and second permanent molars and up to the 14th birthdate.
5. Crowns, jackets, inlays and onlays are benefits on the same tooth only once every 5 years and consistent with professionally recognized standards of dental practice.
6. 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.
7. Denture relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice.
8. 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

1. Lost, stolen or broken appliances
2. 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).
3. Temporomandibular joint syndrome (TMJ) surgical orthodontics.
4. Myofunctional therapy.
5. Treatment of cleft palate, micrognathia, and macroglossia.

Cut here and mail in this form

LIBERTY DENTAL PLAN®

Toll Free: 800.72.SMILE
Fax: 888.704.9930

Purchase or Renew Online:
www.libertydentalplan.com/enrollca1000

– or –

Mail your Enrollment Form and Payment to:

LIBERTY Dental Plan
File 1751
1801 W. Olympic Blvd.
Pasadena, CA 91199