Federal Employees Non-FEHB Dental Plan DHMO Plus 225 Plan Code: CI

CALIFORNIA

Evidence of Coverage (HMO)

Dental, Individual

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Welcome to Health Net Dental

WHAT IS THIS PUBLICATION?

This publication is called an Individual HMO Subscriber *Agreement/Combined Evidence of Coverage and Disclosure Form (Agreement and EOC)*. It is a legal document that explains your dental care plan and should answer many important questions about your benefits.
Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see *Section Ten: Definitions.*

Whether you are the Subscriber of this coverage or enrolled as a Dependent, your Agreement and Combined Evidence of Coverage and Disclosure Form is a key to making the most of your membership. You'll learn about important topics like how to select an Assigned Dental Provider and what to do if you need Emergency Dental Services.

Health Net Dental HMO plans are provided by Dental Benefit Providers of California, Inc. (DBP-CA). Obligations of DBP-CA are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

WHAT ELSE SHOULD I READ TO UNDERSTAND MY BENEFITS?

Along with reading this publication, be sure to review your Schedule of Benefits. Your Schedule of Benefits provides the details of your particular Dental Plan, including any Copayments that you may have to pay when obtaining a dental service. Together, these documents explain your coverage. It is your responsibility to understand your coverage and use your benefits appropriately.

This *Agreement and Combined Evidence of Coverage and Disclosure Form and Schedule of Benefits* provides the terms and conditions of your coverage with Health Net Dental and all applicants have a right to view these documents prior to enrollment. The *Agreement and Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully.

By enrolling in and accepting dental services under this Dental Plan, Members agree to abide by all terms and conditions of this Agreement and EOC.

WHAT IF I STILL NEED HELP?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service Department at 1-866-249-2382 or TTY: 1-800-855-2880

A STATEMENT DESCRIBING HEALTH NET DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

You may correspond with Health Net Dental at the following address:

Health Net Dental
P.O. Box 25187
Santa Ana, California 92799-5187
1-866-249-2382
1-800-855-2880 (TTY)

Or Visit Health Net Dental's Web site:
www.healthnet.com/fehb

1. Getting Started

CHOOSING A PARTICIPATING Dental Provider (CHOICE OF PROVIDERS)

One of the first things you do when joining Health Net Dental is to select a Participating Dental Provider from the Provider Directory, which lists dental offices covered under your Dental Plan. When selecting a Participating Dental Provider make certain your Provider is located within a thirty (30) mile radius of either your Primary Residence or Primary Workplace and write your office selection on your Enrollment Application. When you enroll in the Dental Plan, if the office you selected is not available, or you fail to select an office, we will assign a dental office to you. If you wish to select another dental office, you may contact Customer Service at the number listed below.

Once you select a Participating Dental Provider or we assign a participating dental office to you, you can make an appointment by simply calling that office. The name, address, and phone number of your Assigned Dental Provider appears on your Health Net Dental I.D. Card. If you have any further questions regarding location, office hours or emergency hours or other participating providers in your area, or to request a copy of the Provider Directory, you may contact Customer Service at 1-866-249-2382 or 1-800-855-2880 (TTY) to receive additional information. You may also obtain an online version of the Directory at www.healthnet.com/fehb. If you have questions about the days and hours your Assigned Dental Provider is open, please feel free to contact them directly.

LIABILITY OF MEMBERS FOR PAYMENT

Dental benefits are covered only if dental services are obtained from your Assigned Dental Provider, or are provided as Emergency Dental Services as described in **Section Three: Emergency Dental Services.** The fees for any dental procedures not provided by your Assigned Dental Provider or not provided as Emergency Dental Services may be the responsibility of the Member at the Provider's billed charges.

WHEN YOUR COVERAGE BEGINS

Your Dental Plan coverage will begin on the 1st of the month, at your Assigned Dental Provider, IF:

- You were enrolled before the 1st of the month, AND
- Health Net Dental has received your payment for your first month's benefits.

CONTINUITY OF CARE:

CONTINUITY OF CARE FOR NEW MEMBERS

Under certain circumstances, new Members of Health Net Dental may be able to temporarily continue receiving services from a Non-Participating Provider. This transition assistance is intended for new Members who upon their effective date of coverage, are undergoing treatment for an Acute Condition or Serious Chronic Condition with a Non-Participating Provider, or are scheduled for a surgery or other procedure that is authorized by Health Net Dental as part of a documented course of treatment and has been recommended and documented by a Non-Participating Provider to occur within 180-days of the Member's effective date of coverage.

If you're a new Member and believe you qualify for continuity of care, please call the Customer Service Department at 1-866-249-2382 or 1-800-855-2880 (TTY) and request the form "Continuity of Care for New Enrollees Request." Complete and return this form to Health Net Dental as soon as possible. Upon receiving the completed form, Health Net Dental will review the request in three (3) business days. If you qualify, you will be notified by telephone of the decision and provided with the plan of your care. If you don't qualify, attempts will be made to notify you by telephone of the decision. You will be notified in writing within three (3) business days of the completed review, and alternatives will be offered.

CONTINUITY OF CARE WITH A TERMINATED PROVIDER

You may be eligible to continue receiving care from a terminated dental Provider if the Provider didn't voluntarily end its contract with Health Net Dental. Continuity of Care shall be provided for those Members who are undergoing treatment for an Acute Condition or a Serious Chronic Condition by a Provider whose contract with the Plan has been terminated, or are scheduled for a surgery or other procedure that is authorized by Health Net Dental as part of a documented course of treatment and has been recommended and documented by a terminated Provider to occur within 180-days of the contract's termination date. If you are receiving treatment for any of these conditions, you may contact our Customer Service Department to request continuing treatment by the terminated dental Provider.

Unless the Plan's termination of the Provider's contract is for professional disciplinary reasons as described in California Business and Professions Code §805 (a)(6), or for fraud or other criminal activity, the Plan will allow the Member to continue treatment with the terminated Provider. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were in the Provider's contract prior to termination by Health Net Dental. Rates for the dentist's services must be similar to rates and methods of payment used by the Plan for currently contracting Providers providing similar services who are not capitated. If these various conditions are not met, you will not be eligible to continue the services of the terminated Provider.

Health Net Dental must pre-authorize or coordinate services for continued care. If you have any questions, want to appeal a denial, or would like a copy of Health Net Dental's Continuity of Care Policy, call our Customer Service Department.

2. Seeing the Dentist

SCHEDULING APPOINTMENTS

To visit your dentist, simply make an appointment by calling your Assigned Dental Provider. When you see your dentist you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the dental service. Your Copayments are outlined in your Schedule of Benefits. More detailed information can also be found in **Section Six: Payment Responsibility**.

SECOND OPINIONS

A Member, or his or her treating Assigned Provider, may submit a request for a second opinion to Health Net Dental by writing or calling our Customer Service Department at 1-866-249-2382 or 1-800-855-2880 (TTY). Referrals to a Participating Provider for a second dental opinion will be provided when requested. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function; or the normal timeframe for the decision-making process, as described below, would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function, a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after Health Net Dental's receipt of the information reasonably necessary and requested by Health Net Dental to make the determination. When the Member's condition does not create an imminent and serious threat to his or her health, a request for a second opinion shall be processed in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after receipt of the information reasonably necessary and requested by Health Net Dental to make the determination. The requesting Assigned Provider will be notified both verbally and in writing within twenty-four (24) hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within two (2) business days.

Second dental opinions will be rendered by an appropriately qualified dental professional. An appropriately qualified dental professional is a licensed health care dental Provider who is acting within his or her scope of practice and who possesses the clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second dental opinion.

If the Member is requesting a second dental opinion about care received from his or her Assigned Dental Provider, the second dental opinion will be provided by an appropriately qualified health care professional within the Health Net Dental Participating Provider network. If the Member is requesting a second dental opinion about care received from a Specialist, the second dental opinion will be provided by a Specialist within the Health Net Dental Participating Provider network of the same or equivalent specialty.

A second dental opinion is an examination by an appropriately qualified dental professional documented by a consultation report. The consultation report will be made available to the Member and Health Net Dental, and may include an evaluation of previously performed procedures, as well as any recommended procedures or tests that the dental professional providing the second opinion believes are appropriate. If the Provider giving the second dental opinion recommends a particular treatment, diagnostic test or service covered by Health Net Dental, the treatment, diagnostic test or service will be provided or arranged by the Member's Assigned Dental Provider or by an appropriately qualified dental professional within the Health Net Dental Participating Provider network. However, the fact that an appropriately qualified dental professional furnishing a second dental opinion recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is a Covered Service under the Member's Health Net Dental Plan. All care is subject to the limitations and exclusions listed in this *Agreement and Combined Evidence of Coverage and Disclosure Form*. The Member shall be responsible for paying any dental Copayments, as set forth in the Member's *Schedule of Benefits*, to the Health Net Dental Participating Provider who renders the second dental opinion to the Member.

3. Emergency Dental Services

What to Do When You Require Emergency Dental Services

EMERGENCIES

If you need Emergency Dental Care (for example, due to pain, bleeding or swelling, infection or drainage) you must contact your Assigned Dental Provider. If you are outside Health Net Dental's Service Area and in need of Urgent Dental Services or if your acute emergent dental condition prevents you from contacting your Assigned Dental Provider, you may receive care by any licensed dentist. However, you must use the emergency dentist ONLY for relief of pain, or to immediately diagnose and treat a condition that a reasonable person with no special knowledge of dentistry under the circumstance would believe that, if not given immediate attention, may seriously jeopardize the health of the member, seriously impair bodily functions, or result in serious dysfunction of a bodily organ or part. Health Net Dental will cover out of area follow up care by a Non-Participating Provider as long as the care continues to meet the definition of Emergency Dental Care.

We will reimburse you for these covered Emergency Dental Services only, subject to applicable Copayments. To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within ninety (90) days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were necessary. We will provide reimbursement within thirty (30) days of receipt.

All reimbursement requests should be mailed to:

Health Net Dental
P.O. Box 30567
Salt Lake City, UT 84130

Include the following information:
- Dentist's name
- Nature of problem
- Date of treatment
- Treatment provided
- Itemized charges

4. Changing Your Assigned Dental Provider

There may come a time when you want or need to change your Assigned Dental Provider. This section explains how to make this change, as well as how we continue your care.

CHANGING YOUR ASSIGNED Dental Provider

You may transfer to another Assigned Dental Provider if you have no Treatment In Progress. All Treatment In Progress started at your current Assigned Dental Provider should be completed before a change, unless a quality of care issue is identified. If you wish to select another dental office, you may contact Customer Service at 1-866-249-2382 or 1-800-855-2880 (TTY). If you elect to change offices without completing Treatment in Progress, you may be responsible for all billed charges by your new Assigned Dental Provider. If you owe your Assigned Dental Provider any money, you will be asked to settle your account at the time you transfer.

Health Net Dental reviews transfer requests on a case-by-case basis. If you meet the above requirements and call us by the 20th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 20th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call Health Net Dental on June 17th to request a new Assigned Dental Provider, the transfer will be effective on July 1st. If you meet the above requirements and you call Health Net Dental on June 21st, the transfer will be effective August 1st.

Transfer of records at the Member's initiation will be subject to a duplication fee of $.25 per page or $.50 per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. Duplication of x-rays will be subject to a fee of $10.00 per sheet.

Should a Participating Provider not be available within a reasonable distance from your Primary Residence or Primary Work place, you will be referred by Health Net Dental to a Non-Participating Provider and instructed on reimbursement procedures for service costs in excess of Plan Copayments. For reimbursement procedure information, please contact Customer Service at 1-866-249-2382 or 1-800-855-2880 (TTY).

WHEN WE CHANGE YOUR ASSIGNED PARTICIPATING Dental Provider

Under special circumstances, Health Net Dental may require that a Member change his or her Assigned Dental Provider. Generally, this happens at the request of the Assigned Dental Provider after a material detrimental change in its relationship with a Member. If this occurs, we will notify the Member of the effective date of the change, and we will transfer the Member to another Assigned Dental Provider, provided he or she is medically able and there is an alternative Assigned Dental Provider available.

Health Net Dental will also notify the Member in the event that the agreement terminates between Health Net Dental and the Member's Assigned Dental Provider. If this occurs, Health Net Dental will provide thirty (30) days' notice of the termination. Health Net Dental will also assign the Member a new Assigned Dental Provider. If the Member would like to select a different Assigned Dental Provider, he or she may do so by contacting Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new Assigned Dental Provider

5. Your Dental Benefits

DENTAL BENEFITS

Your dental benefits include *specific* diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral surgery, and other services, as applicable to your specific Health Net Dental plan. You should refer to your *Schedule of Benefits* for a complete list of the Dental Plan's benefits. Services not specifically included in this *Agreement and Combined Evidence of Coverage and Disclosure Form and Schedule of Benefits* are not covered. Listed procedures in the *Schedule of Benefits* are Covered Services only when diagnosed as appropriate treatment by your Assigned Dental Provider. For any Copayments that may be associated with a benefit, you should also refer to your *Schedule of Benefits*.

Health Net Dental Participating Providers and contracted Specialists may offer Members dental services that are not included on the Schedule of Benefits, and for which there are no alternative listed Covered Services. In such cases, the Health Net Dental Participating Provider and contracted Specialist may offer the service at the Provider's Billed Charges. For example, if a Participating Provider offers, and the Member consents to cosmetic tooth bleaching, there is no alternative Covered Service and the Participating Provider may charge the Provider's Billed Charges.

Health Net Dental Participating Providers will ask all Members to sign an informed consent document detailing the risks, benefits and alternatives to all recommended treatments. The Member may choose the least expensive clinically acceptable procedure (such as extraction and not a crown and root canal therapy). In the performance of recommended dental treatments, outcomes cannot always be accurately

predicted. Sometimes, during a specific procedure, an immediate change in treatment may be required. In these instances, the Participating Provider must stop the procedure and fully inform the Member of the change in treatment, risks, and financial impact.

TREATMENT PLAN DECISION-MAKING WHEN TWO OR MORE TREATMENT ALTERNATIVES ARE COVERED SERVICES

When several Covered Services are treatment alternatives for diagnosed care, each alternative is considered a Covered Service. The determination of which Covered Service best meets the Member's needs is the decision of the Assigned Dental Provider in concert with the Member. In such cases, either Covered Service would be available to the Member at the listed Copayment. An example of this situation is the decision with regard to the replacement of a missing tooth. In this scenario, either the removable partial denture or the fixed bridges would be considered Covered Services. The choice would be made by the Assigned Dental Provider and Member considering professionally recognized standards of care, clinical condition of each restoration, technical difficulty of both restorative alternatives, and any other factors that may be present with regard to the Member's specific dental condition.

LIMITATION OF BENEFITS

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating Health Net Dental selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating Health Net Dental selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to the specified co-payment for each crown/bridge unit.
4. There is a $75 co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) months.
2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a Health Net Dental Plan, unless due to the loss of a natural functioning tooth. Replacements will be a benefit under this Plan only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the treating Health Net Dental selected general dentist.
3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your Health Net Dental selected general or specialty care dentist's usual and customary fees.

General Exclusions

1. Services performed by any dentist not contracted with Health Net Dental, without prior approval (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
3. Any dental services, or appliances, which are determined to be not reasonable and/ or necessary for maintaining or improving the member's dental health, as determined by the Health Net Dental selected general dentist.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the Armed Forces of any country or international authority.
12. Dental services considered experimental in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

Orthodontic Exclusions & Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment.

If you terminate coverage from the Health Net Dental Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a Health Net Dental selected general dentist or Health Net Dental contracted orthodontist in order for the co-payments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.
3. The following are not included as orthodontic benefits:
   A. Repair or replacement of lost or broken appliances;
   B. Retreatment of orthodontic cases;
   C. Treatment involving:
      i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
      ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      iii. Treatment related to temporomandibular joint disorders;
      iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

6. Payment Responsibility

WHAT ARE PREMIUMS? (Prepayment Fees)

Dental Plan Premiums are fees a Subscriber pays to cover the basic costs of the Dental Plan for himself or herself and any enrolled Dependent. Your monthly Dental Plan premium rate is based on the Service Area in which you live (Primary Residence) or work (Primary Workplace) and your selected Dental Provider. A Subscriber shall pay the Dental Plan Premiums directly to Health Net Dental when due. Dental Plan Premiums must be received by Health Net Dental by the 30th of the month to be effective on the first of the following month (i.e. January 30th for February 1st coverage). If you have questions about the amount, method and frequency of this payment, contact Customer Service.

All payments are to be made payable to Health Net Dental and mailed to:

Health Net Dental
P.O. Box 894702
Los Angeles, CA 90189-4702

All applications MUST be received by the 15th of the month to be effective the first of the following month (i.e. January 15th for February 1st coverage). Any/all enrollment fees MUST accompany the application and are non-refundable.

All applications must be mailed to:

Health Net Dental
IFP Enrollment
P.O. Box 1150
Rancho Cordova, CA 95741-1150

Dental Plan Premiums are due in full on a monthly basis by electronic transfer or with an annual payment by check. Failure to provide payment by the due date may result in termination or non-renewal of Subscriber, as set forth in **Section Seven: Member Eligibility**

During the contract year, we will not increase Dental Plan Premiums unless we have delivered a written notice to you not less than 30 days prior to the effective date of the change.

WHAT ARE COPAYMENTS? (Other Charges)

Copayments are a Member's share of the costs for Covered Services that are paid to the Participating Provider at the time services are rendered. A Member must always be prepared to pay the Copayment during a visit to the Member's Assigned Dental Provider. Failure to pay a Copayment may result in termination of a Member's coverage under this Dental Plan. A schedule of applicable Copayments is set forth in the Schedule of Benefits which is made a part of this Agreement and EOC.

IF YOU GET A BILL (Reimbursement Provisions)

Your Assigned Dental Provider will bill you for services that are not covered by this Dental Plan. If you are billed for a Covered Service by your Assigned Dental Provider, and you feel this billing is in error, you should do the following:

1. Call the Assigned Dental Provider to let them know you believe you have received a bill in error.
2. If you are unable to resolve this issue, please write to Health Net Dental Customer Service at:

   Health Net Dental
   P.O. Box 30567
   Salt Lake City, UT 84130

Include your name, your Health Net Dental ID number and a brief note and a copy of the bill. The note should also include the date of service, the nature of the service and the name of the Provider Group who provided your care. No claim form is required. If you need additional assistance, call our Customer Service Department at 1-866-249-2382 or 1-800-855-2880 (TTY).

Should Health Net Dental pay any fees for services that are the responsibility of the Member, the Member shall reimburse Health Net Dental for such payment. Failure to reimburse Health Net Dental or reach reasonable accommodations with Health Net Dental concerning repayment within thirty (30) days after Health Net Dental's request for reimbursement shall be grounds for termination of a Member's membership pursuant to **Section 7: Member Eligibility - Termination for Good Cause**. The exercise of Health Net Dental's right to terminate the Member shall not affect the Plan's right to continue enforcement of its right to reimbursement from the Member.

YOUR BILLING PROTECTION

All Health Net Dental Members have rights that protect them from being charged for Covered Services in the event Health Net Dental fails to pay a Participating Provider, a Participating Provider becomes insolvent, or a Participating Provider breaches its contract with Health Net Dental. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the Schedule of Benefits.

In the event of a Participating Provider's insolvency, Health Net Dental will continue to arrange for your benefits. If for any reason Health Net Dental is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of Health Net Dental insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your Health Net Dental

Assigned Dental Provider. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Provider or Emergency Services from a Non-Participating Provider.

NOTE: If you receive a bill because a Non-Participating Provider refused to accept payment from Health Net Dental, you may submit a claim for reimbursement.

WORKERS' COMPENSATION

Should any benefit or service be rendered as a result of a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to Health Net Dental or the Participating Provider who rendered the services. Any reimbursement in excess of the reasonable value of the services performed shall be refunded by Health Net Dental or the Participating Provider who rendered the services.

Health Net Dental will not provide or arrange for benefits, services or supplies required as a result of a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law, To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board, if necessary.

If for any reason Health Net Dental provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse Health Net Dental for the benefits, services or supplies provided or arranged for immediately after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected as a result of a Workers' Compensation action in trust for Health Net Dental. The amount that must be reimbursed to Health Net Dental will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits furnished to him or her or on his or her behalf by Health Net Dental for each incident. If the Member receives a settlement from Workers' Compensation coverage that includes payment of future medical costs, the Member must reimburse Health Net Dental for any future medical expenses associated with this judgment if Health Net Dental covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, Health Net Dental will provide or arrange for benefits until such dispute is resolved if the Member signs an agreement to reimburse Health Net Dental for 100% of the benefits provided.

Health Net Dental will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provision of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose Employer has not complied with the laws and regulations governing Workers' Compensation Insurance, provided that such Member has sought and received Covered Services in accordance with this Dental Plan.

Third Party Liability—Expenses Incurred Due to Liable Third Parties are Not Covered

Dental care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, liable third party) is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Dental Plan. Liability insurance cases: Dental care which is covered under automobile, medical, no-fault or similar type is also excluded from coverage under this Dental Plan. However, in all cases, Health Net Dental will pay for the arrangement or provision of dental services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the Section of the *Agreement and Combined Evidence of Coverage and Disclosure Form* captioned "Health Net's Right To The Repayment Of A Debt As A Charge Against Recoveries From Third Parties Liable For A Member's Dental Expenses."

HEALTH NET DENTAL'S RIGHT TO THE REPAYMENT OF A DEBT AS A CHARGE AGAINST RECOVERIES FROM THIRD PARTIES LIABLE FOR A MEMBER'S DENTAL EXPENSES

If a Member is injured by a liable third party, the Member agrees to give Health Net Dental, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to Health Net Dental, which debt shall include the cost of arranging or providing otherwise covered dental care services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to Health Net Dental, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member's dental care services for injuries caused by a liable third party.

NON-DUPLICATION OF BENEFITS WITH AUTOMOBILE, ACCIDENT OR LIABILITY COVERAGE

If you are receiving benefits as a result of automobile, accident or liability coverage, Health Net Dental will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected, and to notify Health Net Dental of such coverage when available. Health Net Dental will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your dental care services exceeds such coverage.

7. Member Eligibility

This section describes how you become a Health Net Dental Member. It will also answer other questions about eligibility

WHO IS ELIGIBLE TO RECEIVE BENEFITS UNDER THIS PLAN

There are two kinds of Health Net Dental Members: Subscribers and enrolled Dependents. The Subscriber is the person who enrolls after meeting the eligibility requirements of Health Net Dental. A subscriber pays the premium to Health Net Dental for his or her dental care coverage for him or herself and any enrolled Dependents. Should Health Net Dental determine that you or a Dependent no longer meet the coverage terms of the Dental Plan contract, Health Net Dental will advise you or your Dependent that you are no longer eligible. Refer to this Section entitled "Ending Coverage".

Your eligible Dependents (for purposes of the Dental Plan) may include your Spouse or domestic partner and all children, in accordance with the limitations in the items noted below, who are unmarried and chiefly dependent upon you for support. Your eligible Dependents will also include all newborn infants. Their benefits will begin at the moment of their birth. All adopted foster, and stepchildren will be eligible from the date of their placement with you.

The following Dependents are eligible to enroll in Health Net Dental:

1. The Subscriber's Spouse or Domestic Partner,
2. The biological children of the Subscriber or the Subscriber's Spouse (step-children) who are up to age 26;
3. Children who are legally adopted or placed for adoption with the Subscriber or the Subscriber's Spouse who are under the Limiting Age
4. Children for whom the Subscriber or the Subscriber's Spouse has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to Health Net Dental upon request; and
5. Children for whom the Subscriber or the Subscriber's Spouse is required to provide dental insurance coverage pursuant to a Qualified Medical Child Support Order, assignment order, or medical support order.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- They were born to a single person or unmarried couple;
- They are not claimed as dependents on a Federal Income Tax Return;
- They do not reside with the Subscriber or within the Health Net Dental Service Area.

ELIGIBILITY

All Members must meet all eligibility requirements established by Health Net Dental (except as otherwise required by the Health Insurance Portability and Accountability Act (HIPAA). See below for details. Health Net Dental's eligibility requirements are:

- Be a United States citizen or lawful permanent resident of the United States;
- Have a Primary Residence within California;
- Select an Assigned Dental Provider located within a thirty (30) mile radius of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a Qualified Medical Child Support Order);

All applicants for coverage must complete and submit to Health Net Dental all applications or other forms or statements that Health Net Dental may reasonably request.

Enrollment is the completion of a Health Net Dental enrollment form (or a non-standard enrollment form approved by Health Net Dental) by the Subscriber on his or her own behalf or on the behalf of any eligible Dependent. Enrollment is conditional upon acceptance by Health Net Dental, and the timely payment of applicable Dental Plan Premiums. Health Net Dental may at its discretion, and subject to specific protocols, accept enrollment data through an electronic submission.

Your Dental Plan coverage will begin on the 1st on the month, at your Assigned Dental Provider, if:

- You were enrolled before the 1st of the month, and
- Health Net Dental has received your payment for your first month's benefits.

ADDING DEPENDENTS TO YOUR COVERAGE

If the Subscriber wishes to apply for coverage for a Spouse or any other Dependent not currently covered by this Plan, contact Customer Service at 1-800-909-3447. The commencement date of coverage under this Plan shall generally be the first day of the month following Health Net Dental's approval of the Enrollment application and verification of Member's eligibility in accordance with the terms of this *Agreement and EOC*.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Member (or a person otherwise eligible to enroll in Health Net Dental) may enroll a child who is eligible to enroll in Health Net Dental upon presentation of a request by a District Attorney, State Department of Health Services, or a court order to provide medical support for such a dependent child.

A person having legal custody of a child or a custodial parent who is not a Health Net Dental Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling Health Net Dental's Customer Service Department. A copy of the court or administrative order may be required with the Enrollment application. Information including, but not limited to, the ID card, *Agreement and Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by Health Net Dental of an Enrollment form with the court or administrative order attached.

Except for Emergency Dental Care, to receive coverage, all care must be provided or arranged in the Health Net Dental Service Area by the designated Assigned Dental Provider, as selected by the custodial parent or person having legal custody.

CONTINUING COVERAGE FOR DISABLED DEPENDENTS

Certain Dependents who would otherwise lose coverage under the Dental Plan due to their attainment of the Limiting Age, 26, may extend their coverage under the following circumstances:

DISABLED DEPENDENTS: Enrolled Dependents who attain the Limiting Age, 26, may continue enrollment in the Dental Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The Dependent resides within the Service Area with the Subscriber or the Subscriber's separated or divorced Spouse or the terminated Domestic Partner;
2. The Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition;
3. The Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
4. The mental or physical condition existed continuously prior to reaching the Limiting Age.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, Health Net Dental will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age, unless proof of such incapacity and dependency is provided to Health Net Dental by the Member within 60 days of receipt of notice. Health Net Dental shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until Health Net Dental makes a determination.

Health Net Dental may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, Health Net Dental may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the subscriber, must provide Health Net Dental with the requested information within 60 days of receipt of the request. The child must have been covered as a Dependent of the Subscriber or Spouse under a previous health plan at the time the child reached the age limit.

RENEWAL PROVISIONS

This *Agreement and EOC* with Health Net Dental is renewable, subject to all the terms and conditions of the Agreement and EOC. Health Net Dental may change your Dental Plan benefits and Premium at renewal upon 30 days written notice to Subscriber. If Health Net Dental terminates this *Agreement and EOC*, reinstatement is subject to all the terms and conditions of the *Agreement and EOC*.

ENDING COVERAGE (TERMINATION OF BENEFITS)

Termination by Subscriber

Subscriber may terminate this *Agreement and EOC* on his or her behalf or on behalf of a Dependent by giving a minimum of 30 days advance written notice of termination to Health Net Dental. Subscriber's termination must always be effective on the first day of the month. Subscriber shall continue to be liable for Dental Plan Premiums for all Members enrolled in the Dental Plan until the effective date of termination.

If your Membership, or that of a Dependent terminates due to death, it is the Member or the Member's family's responsibility to notify Health Net Dental. Health Net Dental will not retroactively reimburse premiums for a period longer than 60 days because the deceased Member's family had not notified Health Net Dental of the Member's death.

Termination by Health Net Dental

Health Net Dental may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by Health Net Dental.
- The Member establishes his or her Primary Residence outside the State of California.
- The Member establishes his or her Primary Residence outside the Health Net Dental Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

TERMINATION FOR GOOD CAUSE:

You are responsible for making the monthly payments for dental benefits up to the date your benefits end. If we cancel the contract because we have not received proper payment, we will only reinstate the contract, once per contract year, as long as we receive all of the premium owed to Health Net Dental, and you are no more than 90 days past due. However, we will not reinstate the contract:

1. If Health Net Dental does not receive your payment within 15 days. In that case, a new application and contract may be required, OR
2. If we receive your payment more than 15 days after the cancellation notice and refund that payment to you within 20 business days, OR
3. If we receive your payment more than 15 days after the cancellation notice and, in return, we issue a new contract to you, clearly showing any differences between the new contract and the cancelled contract.

Health Net Dental has the right to terminate or not renew your coverage under this dental Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated or not renewed if you fail to pay any required Copayments, coinsurance or charges owed to a Provider or Health Net Dental for Covered Services. To be subject to termination or non-renewal under this provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. Health Net Dental will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30 day notice period.
- **Fraud or Misrepresentation.** Your coverage may be terminated or not renewed if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of Health Net Dental, its Participating Providers or other dental care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date Health Net Dental mails the notice of termination, unless Health Net Dental has specified a later date in that notice.
- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired Health Net Dental's ability to furnish or arrange services for you or other Members, or substantially impaired a Provider(s) ability to provide services to other patients. Termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the Health Net Dental and lose the right to re-enroll in Health Net Dental in the future. **Under no circumstances will a Member be terminated due to health status or the need for dental care services.** Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Customer Service Department.

ENDING COVERAGE: SPECIAL CIRCUMSTANCES FOR ENROLLED DEPENDENTS

Enrolled Dependents terminate on the same date of termination as the Subscriber. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age and do not qualify for extended coverage as a disabled Dependent. Please refer to the section "Continuing Coverage for Disabled Dependents."

8. Complaints, Disputes and Arbitration

In this section you will find out what to do if you're having a problem with your dental care plan, including how to appeal a dental care decision by Health Net Dental or one of our Participating Providers. You'll learn the process that's available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

WHAT IF YOU HAVE A PROBLEM

Health Net Dental's top priority is meeting our Members' needs, and that means providing responsive service. If you ever have a question or problem, your first step is to call our Customer Service Department at 1-866-249-2382 or 1-800-855-2880 (TTY). A Customer Service Representative will make every effort to assist you and attempt to find a resolution to your situation.

If you feel that we haven't assisted you or that your situation requires additional action, you may also request a formal appeal or quality review. To learn more about this, read the following section, "Appealing a Dental Care Decision".

APPEALING A DENTAL CARE DECISION

Our appeals and quality of care review procedures are designed to deliver a timely response and resolution to your complaints. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the complaint. You may submit a formal appeal within 180 days of your receipt of an initial determination through our Appeals Department. To initiate an appeal or request a quality of care review, call our Customer Service Department at 1-866-249-2382, or 1-800-855-2880 (TTY) where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at www.healthnet.com/fehb or write to the Appeals Department:

Health Net Dental Appeals
Post Office Box 30569
Salt Lake City, UT 84130
1-866-249-2382 or 1-800-855-2880 (TTY)

This action will initiate the following Appeals Process (except in the case of Expedited Review as discussed below). You may submit written comments, documents, records and any other information relating to your appeal. Health Net Dental will review your appeal and if the appeal involves a clinical issue, the necessity of treatment, or the type of treatment or level of care proposed or utilized, the determination will be made by a dental reviewer who has the education, training and relevant expertise in the field of dentistry necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

APPEALS PROCESS

Our Grievance Department will acknowledge receipt of your complaint within five (5) calendar days, review it, and make a determination within a reasonable period of time appropriate to the dental circumstances, but no later than thirty (30) calendar days after Health Net Dental's receipt of the complaint.

For determinations *denying dental services* based on a finding that the services are not Covered Services, the written response will specify the provisions in the *Agreement and EOC* and *Schedule of Benefits* that exclude that coverage.

All complaints that involve *quality of care issues* are referred to Health Net Dental's Grievance Department for review. Complaints that affect a Member's immediate condition will receive immediate review. Health Net Dental will investigate the complaint, consult with Member's Assigned Dental Provider and any other Health Net Dental departments and review dental records as necessary. You may need to sign an authorization to release your dental records from any Non-Participating Provider.

Upon completion of the review, but no later than thirty days from Health Net Dental's receipt of the complaint, the Member will be notified in writing of the Plan's determination. The results of the quality of care review are confidential.

If a Member has asserted a claim for benefits or reimbursement as part of a quality of care complaint, the claim for benefits or reimbursement will be reviewed through the appeals process described previously.

EXPEDITED REVIEW

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function will be immediately referred to Health Net Dental's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, Health Net Dental will immediately inform you in writing of your review status and your right to notify the Department of Managed Health Care (DMHC) of the grievance, and provide you and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three (3) calendar days from receipt of the grievance. You are not required to participate in the Health Net Dental appeals process prior to contacting the DMHC regarding your expedited appeal.

VOLUNTARY MEDIATION AND BINDING ARBITRATION

If the Member is dissatisfied with Health Net Dental's appeals process determination, the Member may request that Health Net Dental submit the appeal to voluntary mediation and/or Binding Arbitration in accordance with the Comprehensive Rules of JAMS.

1. **Voluntary Mediation** – In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request to Health Net Dental for voluntary mediation. If all of the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the Comprehensive Rules of JAMS, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

2. **Binding Arbitration** - Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), between Member (including any heirs or assigns) and DBP-CA, or any of its parents, subsidiaries or affiliates (collectively, "DBP-CA Entities") shall be submitted to Binding Arbitration; however, in the event the amount in controversy in the dispute including any claims of damage is not greater than $5,000.00, such disputes are not subject to Binding Arbitration. Disputes in which more than $5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and DBP-CA Entities further agree that neither the Court nor any arbitrator shall have the power to delay arbitration of any dispute or to refuse to order any dispute to arbitration, under any provision of Section 1281 et seq. of

the California Code of Civil Procedure (including but not limited to 1281.2(c), or any successor or replacement provision thereto, of any comparable provision of any other state law. Member and DBP-CA further specifically agree that any disputes about the scope of any arbitration or about the arbitration or about the arbitrability of any dispute shall be determined by the arbitrator. Member and DBP-CA Entities are giving up their constitutional rights to have any such dispute decided in a court of law before a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS in effect at the time of the arbitration, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules of JAMS will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship and to prevent any such hardship or unconscionability, DBP-CA Entities may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and provided JAMS approves such application. Please contact DBP-CA for more information on how to obtain a hardship application. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of Binding Arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking more than $5,000.00 in damages, restitution, or other monetary relief, shall be subject to Binding Arbitration as provided herein and any claim for permanent injunctive relief shall be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration**.**

BY ENROLLING IN HEALTH NET DENTAL BOTH MEMBER (INCLUDING ANY HEIRS OR ASSIGNS) AND HEALTH NET DENTAL AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS AGREEMENT AND COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care (the "DMHC" or "Department") is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at **1-866-249-2382** or **1-800-855-2880 (TTY)** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and **TTY line (1-877-688-9891)** for the hearing and speech impaired. The Department Internet Web site **http://www.hmohelp.ca.gov** has complaint forms and instructions online.

9. General Information

WHAT SHOULD I DO IF I LOSE OR MISPLACE MY ID CARD?

If you should lose your I.D. card, simply call our Customer Service Department at 1-866-249-2382.

DOES HEALTH NET DENTAL OFFER A TRANSLATION SERVICE?

Health Net Dental uses a telephone translation service for almost 140 languages and dialects. That is in addition to select Customer Service representatives who are fluent in Spanish.

DOES HEALTH NET DENTAL OFFER HEARING AND SPEECH IMPAIRED TELEPHONE LINES?

Health Net Dental has a dedicated telephone number for the hearing and speech impaired. This telephone number is 1-800-855-2880.

WHO SHOULD I CALL IF I HAVE A BILLING QUESTION?

If you have a billing question, simply call 1-800-909-3447.

HOW IS MY COVERAGE PROVIDED UNDER EXTRAORDINARY CIRCUMSTANCES?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Providers will do their best to provide the dental services you need. Under these extreme conditions, go to the nearest dental provider for Emergency Dental Services. Health Net Dental will later provide appropriate reimbursement.

HOW DOES HEALTH NET DENTAL COMPENSATE ITS DENTAL PROVIDERS?

Health Net Dental itself is not a Provider of dental services. Health Net Dental typically contracts with independent Providers to provide dental services to its Members. None of the contracting dental Providers or their employees are employees or agents of Health Net Dental, and neither Health Net Dental nor any employee of Health Net Dental is an employee or agent of any contracting Participating Provider. Once they are contracted, they become Health Net Dental Participating Providers. Health Net Dental's network of Participating Providers includes individual practitioners, group practices, and facilities.

Most of our Participating Providers receive an agreed upon monthly payment from Health Net Dental to provide Covered Services to Members. The monthly payment may be a fixed dollar amount for each Member or a fixed dollar amount for each Member plus a supplemental payment for certain procedures. This monthly payment plus supplemental payment and the Member's Copayment represents the total compensation for professional services directly performed by the dental Provider and may also cover certain referral services. Other dentists are paid on a percentage of usual and customary fees or a discount fee for service basis. Health Net Dental does not compensate nor does it provide any financial bonuses or any other incentives to its Participating Providers based on their utilization patterns.

ORGAN AND TISSUE DONATION

Transplantation is one of the most remarkable success stories in the history of medicine. It is the only hope for thousands of people suffering from organ failure, or in desperate need of corneas, skin, bone or other tissue. Tragically, the need for donated organs and tissues continues to outpace the supply. Nearly 50,000 Americans are waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others. You can save lives and enable recipients to return to work or lead productive lives and others to see for the first time.

MOST ANYONE CAN BE A DONOR

Almost everyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have concerns about organ donation, speak with your family, doctor, clergy member or friends. Most importantly, get the information you need to make a responsible decision that you and your family support.

BE SURE TO SHARE YOUR DECISION

Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a family member gives consent at the time of your death – even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

HOW CAN I LEARN MORE

- To get your donor card and information on organ & tissue donation call (800) 355-SHARE or (800) 633-6562
- Request Donor Information from your local Department of Motor Vehicles (DMV)
- On the internet, contact
  - All About Transplantation and Donation (www.transweb.org)
  - Department of Health & Human Services at http://www.organdonor.gov
- Sign the donor card in your family's presence
- Have your family sign as witnesses and pledge to carry out your wishes
- Keep the card with you at all times where it can be easily found

Remember, even if you have signed something, you must tell your family so they can act on your wishes.

PUBLIC POLICY PARTICIPATION

Health Net Dental gives its Members the opportunity to participate in establishing the public policy of the Plan. One third of Health Net Dental's Board of Directors is compromised of Plan Members. If you are interested in participating in the establishment of Health Net Dental public policy, please call or write our Customer Service Department.

GENERAL PROVISIONS

Health Net Dental is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and to Chapter 2 of Title 28 of the California Code of Regulations. Any provision required in this contract by either of those statutes will apply to Health Net Dental, whether or not it is mentioned here.

Acceptance of Agreement and Evidence of Coverage and Disclosure Form.

Member accepts the terms, conditions and provisions of this *Agreement and Evidence of Coverage and Disclosure Form* upon completion and

execution of the Enrollment form and by making his or her initial payment to Health Net Dental at the time of submission of the Enrollment form.

Entire Agreement

This *Agreement and Evidence of Coverage and Disclosure Form*, including all exhibits, attachments and amendments, contains the entire understanding of Subscriber and Health Net Dental with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations or communications, when written or oral between Subscriber and Health Net Dental with respect to the subject matter of the Agreement and Evidence of Coverage and Disclosure Form.

10. Definitions

Health Net Dental is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Agreement and Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*.

ACUTE CONDITION - A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration.

ASSIGNED Dental Provider - The dental office contracted with Health Net Dental where you and your Dependents are assigned to receive dental benefits.

BILLED CHARGES - The Providers usual charge for furnishing treatment, services, or supplies.

BINDING ARBITRATION - The submission of a dispute to one or more impartial persons for a final and binding decision, except fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

COPAYMENT - The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

COVERED SERVICES - Dental services that are listed in this *Agreement and Combined Evidence of Coverage and Disclosure Form* in **Section Five: Your Dental Benefits** and *Schedule of Benefits* when they are diagnosed as necessary for the dental health of a Member in accordance with professionally recognized standards of practice.

DENTAL PLAN - The benefit plan as described in this *Agreement and Combined Evidence of Coverage and Disclosure Form*, the Schedule of Benefits.

DENTAL PLAN PREMIUMS - Amounts established by Health Net Dental and paid by the Member to Health Net Dental for providing and continuing enrollment of the Member and any enrolled Dependents in Health Net Dental.

DEPENDENT - A Member of a Subscriber's family who is enrolled with Health Net Dental after meeting all of the eligibility requirements of Health Net Dental, and for whom applicable Dental Plan Premiums have been received by Health Net Dental.

DOMESTIC PARTNER – 2 individuals that have:

1. An intimate, committed relationship of mutual caring and intend to remain sole Domestic Partners indefinitely; and
2. Share the same principal residence; and
3. Agree to be responsible for each other's basic living expenses during the Domestic Partner relationship such as food, shelter, or medical expenses; including mutual responsibility over each other's financial obligations; and
4. Both Domestic Partners are age 18 or older; and
5. Neither Domestic Partner is married; and
6. Neither Domestic Partner is related by blood to the other such as a parent, brother, sister, half brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild; and
7. Neither Domestic Partner has a different Domestic Partner now;
8. Neither Domestic Partner has had a different Domestic Partner in the last six (6) months unless a previous Domestic Partnership terminated by death.

For eligibility and enrollment provisions, please contact Health Net Dental for assistance.

EMERGENCY DENTAL SERVICES or EMERGENCY DENTAL CARE - Dental services required to diagnose and treat a dental condition which is manifested by acute symptoms of sufficient severity, including severe pain such that a reasonable person with no special knowledge of dentistry could expect the absence of immediate dental attention to result in placing the Member's health in serious jeopardy, serious impairment to the Member's bodily functions, or serious dysfunction of a bodily organ or part.

LIMITING AGE - Age 26. Disabled Dependents may be eligible for Dependent coverage beyond the Limiting Age.

LABORATORY COST(S) - OR FEE- The actual dental laboratory charge the dentist incurs for a standard Covered Service. For upgraded laboratory costs, Members are responsible for an additional charge, limited to the actual Laboratory Cost incurred by the dentist.

MEMBER - Any Subscriber or Dependent who enrolls in Health Net Dental Dental's Individual Dental Plan and who meets all the applicable eligibility requirements

NON-PARTICIPATING DENTAL PROVIDER - A Provider that has not entered into a written agreement to provide Covered Services to Health Net Dental's Members.

PARTICIPATING DENTAL PROVIDER - A Provider that has entered into a written agreement to provide Covered Services to Health Net Dental's Members.

PLAN - Health Net Dental Plan

PRIMARY RESIDENCE - The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

PRIMARY WORKPLACE – The facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

PROVIDER - A person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the Covered Services described in this *Agreement and Combined Evidence of Coverage and Disclosure Form*, the *Schedule of Benefits*.

SCHEDULE OF BENEFITS - The list of Benefits and Coverages and the authorized Copayment amounts under the Member's Dental Plan as set forth in this *Agreement and Combined Evidence of Coverage and Disclosure Form*.

SERIOUS CHRONIC CONDITION - A medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

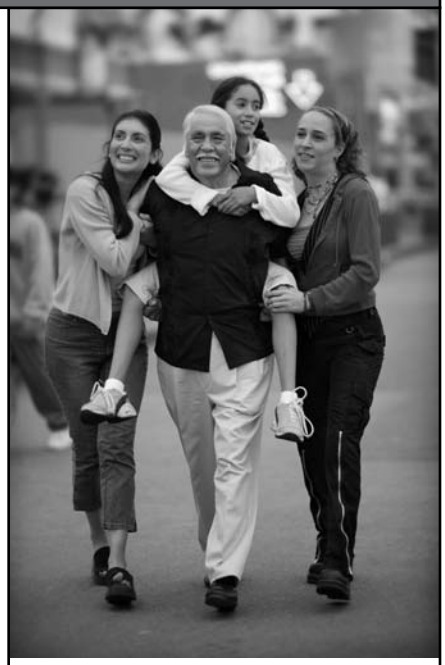
SERVICE AREA - A geographic region in the State of California where Health Net Dental is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

SPOUSE - The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the State of California.

SUBSCRIBER - The individual enrolled in the dental plan for whom the appropriate dental plan Premiums have been received by Health Net Dental except for family dependency, is the basis for enrollment eligibility**.**

TREATMENT IN PROGRESS - A dental procedure(s) (as defined by the American Dental Association's CDT booklet) begun by a Dentist but not yet completed.

URGENT DENTAL SERVICES - Urgently needed services employed to prevent serious deterioration of a Member's health resulting from an unforeseen dental condition or injury for which treatment cannot be delayed until the Member returns to Health Net Dental's Service Area.



ASK TO SEE *your*
TREATMENT PLAN

Sometimes it's difficult to understand exactly what dental treatment you're getting, and why, and how the charges are determined. Dentists are obligated to present all appropriate treatment options, regardless of whether the options are covered by your plan, so it can be confusing when a dentist recommends a treatment that is not covered. Should that occur, remember, there are several things you can do to ensure that you receive appropriate treatment:

1. Ask for a treatment plan

Regardless of the scope of your treatment, your dental provider should present you with a treatment plan. This plan will normally include:

- An explanation of what services the provider is recommending.
- What treatments your insurance plan covers, and in what amounts.
- An estimate of what charges (if any) you will have to pay.

2. Talk to your dentist directly

If you are unsure about either the treatment plan or the charges, never give the go-ahead for treatment without first talking to your dentist. Per the Patient Bill of Rights, as posted by the California Dental Association:

- You have a right to know in advance the type and expected cost of treatment.
- You have a right to ask about treatment alternatives and to be told, in language you can understand, the advantages and disadvantages of each.
- You have a right to ask your dentist to explain all the treatment options regardless of coverage or cost.

3. Talk to Health Net Dental

Member Service representatives are available at 1-866-249-2382 to answer your questions about benefits coverage and charges. They can also locate a dentist who can provide you with a second opinion. And remember — you always have the option of seeing another dentist within your network.

11. Schedule of Benefits

Benefits provided by Dental Benefit Providers of California, Inc.

This Schedule of Benefits lists the services available to you under your Health Net of California dental plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions and Limitations. During the course of treatment, your Health Net selected general dentist may recommend the services of a dental specialist. In addition, non-listed services are available with your Health Net selected general dentist or specialty care dentist at 75% of their usual and customary fees.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention.

* Your Health Net selected general dentist is responsible for coordinating your dental care, and if necessary, referring you to a Health Net contracted specialist, and will submit all required documentation for any necessary referral. For more information, visit www.healthnet.com.

Code	Service	Copayment
Diagnostic Treatment		
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
D9491	Office visit - per visit (including all fees for sterilization and/or infection control)	$5
Radiographs/Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series (including bitewings)	$0
D0220	Intraoral – periapical first film	$0
D0230	Intraoral – periapical each additional film	$0
D0240	Intraoral – occlusal film	$0
D0250	Extraoral – first film	$0
D0260	Extraoral – each additional film	$0
D0270	Bitewing – single film	$0
D0272	Bitewings – two films	$0
D0273	Bitewings – three films	$0
D0274	Bitewings – four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
Tests and Examinations		
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0
Preventive Services		
D1110	Prophylaxis – adult	$0
D1110	Additional-adult prophylaxis (maximum of 2 additional per year)	$35
D1120	Prophylaxis – child	$0
D1120	Additional-child prophylaxis (maximum of 2 additional per year)	$25
D1203	Topical application of fluoride (prophylaxis not included) – child	$0
D1204	Topical application of fluoride (prophylaxis not included) – adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$0
D1510	Space maintainer – fixed – unilateral	$25

Code	Service	Copayment
D1515	Space maintainer – fixed – bilateral	$25
D1520	Space maintainer – removable – unilateral	$35
D1525	Space maintainer – removable – bilateral	$35
D1550	Recementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15
Restorative Treatment		
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$30
D2392	Resin-based composite – two surfaces, posterior	$45
D2393	Resin-based composite – three surfaces, posterior	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65
Crowns		
• An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 co-payment per crown/bridge unit in addition to regular copayments for porcelain on molars.		
• Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatmentplan require an additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.		
D2510	Inlay – metallic – one surface	$185
D2520	Inlay – metallic – two surfaces	$185
D2530	Inlay – metallic – three or more surfaces	$185
D2542	Onlay – metallic – two surfaces	$225
D2543	Onlay – metallic – three surfaces	$225
D2544	Onlay – metallic – four or more surfaces	$225
D2610	Inlay – porcelain/ceramic – one surface	$225
D2620	Inlay – porcelain/ceramic – two surfaces	$225
D2630	Inlay – porcelain/ceramic – three or more surfaces	$225
D2642	Onlay – porcelain/ceramic – two surfaces	$225
D2643	Onlay – porcelain/ceramic – three surfaces	$225
D2644	Onlay – porcelain/ceramic – four or more surfaces	$225
D2650	Inlay – resin-based composite – one surface	$225
D2651	Inlay – resin-based composite – two surfaces	$225
D2652	Inlay – resin-based composite – three or more surfaces	$225
D2662	Onlay – resin-based composite – two surfaces	$225
D2663	Onlay – resin-based composite – three surfaces	$225
D2664	Onlay – resin-based composite – four or more surfaces	$225
D2710	Crown – resin-based composite (indirect)	$225
D2712	Crown – ¾ resin-based composite (indirect)	$225
D2720	Crown – resin with high noble metal	$225
D2721	Crown – resin with predominantly base metal	$225
D2722	Crown – resin with noble metal	$225
D2740	Crown – porcelain/ceramic substrate	$225
D2750	Crown – porcelain fused to high noble metal	$225
D2751	Crown – porcelain fused to predominantly base metal	$225
D2752	Crown – porcelain fused to noble metal	$225
D2780	Crown – ¾ cast high noble metal	$225
D2781	Crown – ¾ cast predominantly base metal	$225
D2782	Crown – ¾ cast noble metal	$225
D2783	Crown – ¾ porcelain/ceramic	$225
D2790	Crown – full cast high noble metal	$225
D2791	Crown – full cast predominantly base metal	$225
D2792	Crown – full cast noble metal	$225
D2794	Crown – titanium	$225
D2799	Provisional crown	$0
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown – primary tooth	$25
D2931	Prefabricated stainless steel crown – permanent tooth	$25
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	$45
D2940	Sedative filling	$0
D2950	Core buildup, including any pins	$70
D2951	Pin retention – per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50
D2953	Each additional indirectly fabricated post – same tooth	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post – same tooth	$30
D2960	Labial veneer (resin laminate) – chairside	$250
D2961	Labial veneer (resin laminate) – laboratory	$300
D2962	Labial veneer (porcelain laminate) – laboratory	$350
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair, by report	$0

Code	Service	Copayment
Endodontics		
All procedures exclude final restoration.		
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$30
D3221	Pulpal debridement, primary and permanent teeth	$55
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$40
D3310	Anterior (excluding final restoration)	$80
D3320	Bicuspid (excluding final restoration)	$125
D3330	Molar (excluding final restoration)	$210
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$135
D3347	Retreatment of previous root canal therapy – bicuspid	$175
D3348	Retreatment of previous root canal therapy – molar	$275
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy/periradicular surgery – anterior	$95
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$95
D3425	Apicoectomy/periradicular surgery – molar (first root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$60
D3430	Retrograde filling – per root	$40
D3450	Root amputation – per root	$95
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	$110
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or	$83
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening – hard tissue	$120
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	$295
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	$210
D4263	Bone replacement graft – first site in quadrant	$180
D4264	Bone replacement graft – each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration – resorbable barrier, per site	$215
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$245
D4271	Free soft tissue graft procedure (including donor site surgery)	$245
D4273	Subepithelial connective tissue graft procedures, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Soft tissue allograft	$380
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$40
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$30
D4910	Additional periodontal maintenance procedures (beyond 2 per 12 months)	$55
D4999	Periodontal charting for planning treatment of periodontal disease	$0
D4999	Periodontal hygiene instruction	$0

Code	Service	Copayment
Removable Prosthodontics		
Includes up to 3 adjustments within 6 months of delivery.		
D5110	Complete denture – maxillary	$260
D5120	Complete denture – mandibular	$260
D5130	Immediate denture – maxillary	$240
D5140	Immediate denture – mandibular	$240
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$240
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$240
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260
D5214	Mandibular partial denture – cast metal framework with resin denture	$260
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$365
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$365
D5281	Removable unilateral partial denture – one piece cast metal bases (including any conventional clasps, rests and teeth) (including clasps and teeth)	$250
D5410	Adjust complete denture – maxillary	$10
D5411	Adjust complete denture – mandibular	$10
D5421	Adjust partial denture – maxillary	$10
D5422	Adjust partial denture – mandibular	$10
D5510	Repair broken complete denture base	$30
D5520	Replace missing or broken teeth – complete denture (each tooth)	$30
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$30
D5630	Repair or replace broken clasp	$35
D5640	Replace broken teeth – per tooth	$30
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$60
D5711	Rebase complete mandibular denture	$60
D5720	Rebase maxillary partial denture	$60
D5721	Rebase mandibular partial denture	$60
D5730	Reline complete maxillary denture (chairside)	$35
D5731	Reline complete mandibular denture (chairside)	$35
D5740	Reline maxillary partial denture (chairside)	$35
D5741	Reline mandibular partial denture (chairside)	$35
D5750	Reline complete maxillary denture (laboratory)	$60
D5751	Reline complete mandibular denture (laboratory)	$60
D5760	Reline maxillary partial denture (laboratory)	$60
D5761	Reline mandibular partial denture (laboratory)	$60
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$60
D5821	Interim partial denture (mandibular)	$60
D5850	Tissue conditioning, maxillary	$20
D5851	Tissue conditioning, mandibular	$20
D5862	Precision attachment, by report	$160

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 co-payment per crown/bridge unit in addition to regular copayments for porcelain on molars.
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.

D6210	Pontic – cast high noble metal	$225
D6211	Pontic – cast predominantly base metal	$225
D6212	Pontic – cast noble metal	$225
D6214	Pontic – titanium	$225
D6240	Pontic – porcelain fused to high noble metal	$225
D6241	Pontic – porcelain fused to predominantly base metal	$225
D6242	Pontic – porcelain fused to noble metal	$225
D6245	Pontic – porcelain/ceramic	$245
D6250	Pontic – resin with high noble metal	$225
D6251	Pontic – resin with predominantly base metal	$225
D6252	Pontic – resin with noble metal	$225
D6253	Provisional pontic	$0
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$150
D6600	Inlay – porcelain/ceramic, two surfaces	$225
D6601	Inlay – porcelain/ceramic, three or more surfaces	$225
D6602	Inlay – cast high noble metal, two surfaces	$225
D6603	Inlay – cast high noble metal, three or more surfaces	$225
D6604	Inlay – cast predominantly base metal, two surfaces	$225
D6605	Inlay – cast predominantly base metal, three or more surfaces	$225
D6606	Inlay – cast noble metal, two surfaces	$225
D6607	Inlay – cast noble metal, three or more surfaces	$225
D6608	Onlay – porcelain/ceramic, two surfaces	$225
D6609	Onlay – porcelain/ceramic, three or more surfaces	$225
D6610	Onlay – cast high noble metal, two surfaces	$225
D6611	Onlay – cast high noble metal, three or more surfaces	$225
D6612	Onlay – cast predominantly base metal, two surfaces	$225
D6613	Onlay – cast predominantly base metal, three or more surfaces	$225

Code	Service	Copayment
D6614	Onlay – cast noble metal, two surfaces	$225
D6615	Onlay – cast noble metal, three or more surfaces	$225
D6710	Crown – indirect resin based composite	$225
D6720	Crown – resin with high noble metal	$225
D6721	Crown – resin with predominantly base metal	$225
D6722	Crown – resin with noble metal	$225
D6740	Crown – porcelain/ceramic	$225
D6750	Crown – porcelain fused to high noble metal	$225
D6751	Crown – porcelain fused to predominantly base metal	$225
D6752	Crown – porcelain fused to noble metal	$225
D6780	Crown – ¾ cast high noble metal	$225
D6781	Crown – ¾ cast predominantly base metal	$225
D6782	Crown – ¾ cast noble metal	$225
D6783	Crown – ¾ porcelain/ceramic	$225
D6790	Crown – full cast high noble metal	$225
D6791	Crown – full cast predominantly base metal	$225
D6792	Crown – full cast noble metal	$225
D6794	Crown – titanium	$225
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$30
D6973	Core build up for retainer, including any pins	$10
D6976	Each additional indirectly fabricated post – same tooth	$40
D6977	Each additional prefabricated post – same tooth	$40
D6980	Fixed partial denture repair, by report	$45
Oral Surgery		
• Includes routine post operative visits/treatment.		
• The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your Health Net selected general or specialty caredentist's usual and customary fees.		
D7111	Extraction, coronal remnants – deciduous tooth	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth – soft tissue	$45
D7230	Removal of impacted tooth – partially bony	$65
D7240	Removal of impacted tooth – completely bony	$80
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Surgical access of an unerupted tooth	$85
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue – hard (bone, tooth)	$0
D7286	Biopsy of oral tissue – soft	$0
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy – transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$60
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$35
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$35
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$40
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue – per arch	$55
D7971	Excision of pericoronal gingiva	$40
Orthodontics		
• Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.		
• Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.		
D8010	Limited orthodontic treatment of the primary dentition	$725
D8020	Limited orthodontic treatment of the transitional dentition	$725

Code	Service	Copayment
D8030	Limited orthodontic treatment of the adolescent dentition	$725
D8040	Limited orthodontic treatment of the adult dentition	$725
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,695
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,695
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,695
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
D8999	Ortho visits beyond 24 months of active treatment or retention	$25 per visit
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia – first 30 minutes	$150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$150
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$45
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit – after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment – limited	$30
D9952	Occlusal adjustment – complete	$60
D9972	External bleaching – per arch	$125
D9999	Broken appointment (less than 24 hour notice)	Not to exceed $25

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat the nerve or the pulp of the tooth due to injury or infection.

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Scaling and polishing of teeth by removal of the plaque above the gum line.

Prosthodontics: The restoration of natural and/or the replacement of missing teeth with artificial substitutes.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings

If there are any conflicts in the provisions of the Evidence of Coverage and this Schedule of Benefits, the provisions of the Evidence of Coverage shall govern.

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This booklet describes your dental plan and includes eligibility information, limitations and exclusions, and other important information. We do encourage all plan members to review this booklet and keep it in a convenient location for future reference.

Should you have questions about your plan, please contact your benefits representative or Health Net Dental member service at 1-866-249-2382.

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