

Health Net Dental HMO¹

HN Plus DHMO 150

This comprehensive Dental HMO (DHMO) plan offers coverage for more than 345 dental procedures, including many preventive and diagnostic procedures at low or no copayment. Access to care is through one of California's largest dental HMO networks.

DHMO plans may be purchased either as a dual choice option with Health Net Dental PPO plans or as a stand-alone plan.

Key Dental HMO features

- Additional cleanings and periodontal maintenance (up to 4 per year)
- Reduced usual and customary fees for non-listed services
- Nitrous oxide and IV sedation (subject to copays)
- Teeth whitening and veneers (subject to copays)
- Orthodontics for children and adults (subject to copays)

Covered procedures (partial list ²)	Member copayment
Diagnostic	
D0150 Comprehensive oral evaluation	\$0
D0210 Intraoral X-rays – complete series	\$0
D9491 Office visit (including all fees for sterilization and infection control)	\$5
Preventive	
D1110 Prophylaxis (cleaning) – adult	\$0
D1110 Additional prophylaxis (up to 2 per year) adult	\$20
D1204 Topical application of fluoride – adult	\$0
Restorative treatment	
D2150 Amalgam (silver filling) – two surfaces	\$0
D2331 Composite (white filling) – two surfaces anterior	\$0
D2392 Composite (white filling) – two surfaces posterior	\$30
Crowns and pontics	
D2751 ³ Crown – porcelain fused to predominantly base metal	\$150
D2962 Labial veneer (porcelain laminate) – laboratory	\$350
Endodontics	
D3320 Root canal – bicuspid (ex. final restoration)	\$95
D3330 Root canal – molar (ex. final restoration)	\$125
Periodontics	
D4341 Periodontal scaling and root planing – 4 or more teeth per quadrant	\$35
Prosthodontics	
D5110 Complete denture – upper	\$175
D7220 Removal of impacted tooth – soft tissue	\$35
Orthodontics	
D8070–90 Comprehensive orthodontic treatment – adult or child	\$1,695
Other general services	
D9230 Nitrous oxide, analgesia, anxiolysis (inhalation)	\$15 per half hour
D9972 External bleaching (teeth whitening) – per arch	\$125

¹Health Net Dental HMO plans are provided by Dental Benefit Providers of California, Inc. (DBP). Obligations of DBP are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

²Refer to your Evidence of Coverage and Schedule of Benefits for the full list of Covered Procedures and Exclusions and Limitations.

³There is a \$75 copayment per crown/bridge unit in addition to regular copayments for porcelain on molars.



Pam White
Health Net

Limitations

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 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 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 copayment 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 copayment per unit in addition to the specified copayment for each crown/bridge unit.
4. There is a \$75 copayment per crown/bridge unit in addition to the specified copayment for porcelain on molars.

Prosthetic

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 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 selected general dentist.
3. Delivery of removable prosthetics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The copayments 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 selected general or specialty care dentist's usual and customary fees.

General exclusions

1. Services performed by any dentist not contracted with Health Net, 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 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, prosthetic 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 and 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 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 selected general dentist or Health Net contracted orthodontist in order for the copayments 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.

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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