Pam White
Health Net

Health Net®

Health Net Dental PPO[1]

DPPO Essential 6 1500

Key Dental PPO features

- Large statewide and national network of dental PPO providers can be found online at **www.healthnet.com** or by calling **1-866-249-2382**.
- Endodontics, periodontics and oral surgery are covered under General Services.
- No waiting period for any covered service.
- Pregnant women are eligible to receive extra services during their second and third trimester, by simply asking their dentist to note the pregnancy, due date and name of attending physician or obstetrician's name on the dental claim form (see Prenatal Dental Care).

Benefit description	*Plan benefits*[2]	
	In-network	**Out-of-network**[3]
Calendar year maximum	$1,500	
Deductible	$50 single / $150 family	$75 single / $225 family
Preventive services (initial/routine oral exam, teeth cleaning and routine scaling, fluoride treatment, sealant (children under 16), space maintainers, X-rays as part of general exam, emergency exam)	100% deductible waived	
Prenatal dental care If medically necessary, women in their second and third trimester are eligible to receive additional prophylaxis, deep cleaning, debridement and periodontal maintenance (Covered expenses do not apply to the calendar year maximum.)	100% deductible waived	
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics)	80% after deductible	80% after deductible
Major services (crowns, removable and fixed bridges, complete and partial dentures)	50% after deductible	50% after deductible
Orthodontia (adult and child)	Not covered	

[1]Health Net Dental PPO plans are underwritten by Unimerica Life Insurance Company. Obligations of Unimerica Life Insurance Company are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

[2]This is only a summary of benefits. Please refer to the Certificate of Insurance for terms and conditions of coverage, including which services are limited or excluded from coverage.

[3]Out-of-network benefits are based on the allowable amount applicable for the same service that would have been rendered by a network provider.

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General limitations

Periodic oral evaluation Limited to 2 times per consecutive 12 months.

Complete series or panorex radiographs Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorex radiographs if taken for diagnosis of third molars, cysts or neoplasms.

Bitewing radiographs Limited to 1 series of films per calendar year.

Extraoral radiographs Limited to 2 films per calendar year.

Dental prophylaxis Limited to 2 times per consecutive 12 months.

Fluoride treatments Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

Space maintainers Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

Sealants Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

Restorations Multiple restorations on one surface will be treated as a single filling.

Pin retention Limited to 2 pins per tooth; not covered in addition to cast restoration.

Inlays and onlays Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

Post and cores Covered only for teeth that have had root canal therapy.

Sedative fillings Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

Scaling and root planing Limited to 1 time per quadrant per consecutive 24 months.

Periodontal maintenance Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.

Full dentures Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

Partial dentures Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

Relining and rebasing dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

Repairs to full dentures, partial dentures, bridges Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

Palliative treatment Covered as a separate benefit only if no other service, other than the exam and radiographs, was performed on the same tooth during the visit.

Occlusal guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

Full mouth debridement Limited to 1 time every consecutive 36 months.

General anesthesia Covered only where clinically necessary.

Osseous grafts Limited to 1 per quadrant or site per consecutive 36 months.

Periodontal surgery Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area.

Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General exclusions

The following are not covered:

1. Dental services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign services are not covered unless required as an emergency.
13. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient noncompliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
18. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
19. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
20. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
21. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
22. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
23. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
24. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
25. Dental services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.
26. Orthodontic services.