Mailing Address:
Health Net Dental Healthy Families Program
340 Commerce, Suite 100
Irvine, CA 92602

Health Net Member Services: 1-800-977-7307
TDD/TTY: 1-800-880-3165
Enrollment Services: 1-800-213-6991

Health Net Dental
provides Healthy Families Program
coverage in 26 counties.

Note: Not all counties have full coverage.

HEALTH NET DENTAL
HEALTHY FAMILIES PROGRAM DENTAL PLAN

A COMPLETE EXPLANATION OF YOUR DENTAL PLAN

Combined Evidence of Coverage and Disclosure Form
October 1, 2012 to September 30, 2013

HF 2012/2013

Health Net®
DENTAL

HEALTHY FAMILIES

Disclosure

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Dental Plan's policies and coverage under the Healthy Families Program (HFP). The Health Plan contract and the HFP regulations (California Code of Regulations, Title 10, Chapter 5.8) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at http://www.mrmib.ca.gov.

Additionally, the HFP regulations require the Dental Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et.seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Dental Plan, even if it is not included in the Evidence of Coverage booklet or the Dental Plan contract.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another Dental Plan, annual requalification, premium payments, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is included in the Healthy Families Program Handbook that was mailed to you by the Healthy Families Program. If you have questions on these topics or would like another copy of the Handbook, please contact the Healthy Families Program at the following address or toll-free telephone number:

Healthy Families Program
P.O. Box 138005
Sacramento, CA 95813-8005
(800) 880-5305
The hearing impaired should call the California Relay Service at 711(TTY).

Additional information about the Healthy Families Program is available at the Managed Risk Medical Insurance Board Website at www.mrmib.ca.gov.

IMPORTANT

Healthy Families Program (HFP) Changes

Effective November 1, 2009

Copayments

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. **This copayment increase does not apply to members in Income Category A. Please refer to the Definitions Section, page 5 of this Combined Evidence of Coverage and Disclosure Form (EOC/DF) booklet to read more about the HFP Income Categories.**

Your monthly premium and copayments are determined by your income category. For more information about Income Categories A, B, and C go to the HFP website address below or refer to your HFP handbook and read about the HFP Income Categories.

http://www.healthyfamilies.ca.gov/HFProgram/Determine_Premium.aspx

Effective January 18, 2011

Timely Access to Non-Emergency Dental Care Services

The California Department of Managed Health Care (DMHC) adopted new regulations (Title 28, Section 1300.67.2.2) for health plans to provide timely access to non-emergency health care services to members. Health care service plans must comply with these new regulations by January 18, 2011.

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Introduction

Using this Booklet

This booklet, called the Combined Evidence of Coverage and Disclosure Form, or "EOC", contains detailed information about Healthy Families Program benefits, how to obtain benefits, and the rights and responsibilities of Healthy Families Program members. Please read this booklet carefully and keep it on hand for future reference. Individuals with special health care needs should read carefully those sections that apply to them.

Throughout this booklet, "you", "your", and "Member" refers to the child or children enrolled in the Healthy Families Program. "We", "us", and "our" always refers to Health Net. "Your provider" refers to a licensed dentist who is responsible for providing dental services to you.

Welcome! About the Dental Plan

Welcome and thank you for selecting Health Net as your Healthy Families Program Dental Plan.

This booklet describes the dental benefits plan being offered by Health Net to Members who have selected Health Net as their Dental Plan.

After enrollment of the Member in Health Net, this booklet will be the Evidence of Coverage and Disclosure Form for You and the Member. This booklet contains important information. Please keep it in a safe place, available for quick reference.

Please read this booklet completely and carefully so You will know the Member's benefits and responsibilities as a Health Net Member. Please give extra attention to those sections that explain how to choose a Primary Care Dentist, the Covered Services that are available to the Member, how and where to obtain the Covered Services the Member may need, and what to do in the event of a dental emergency. The

Member's Primary Care Dentist will be responsible for providing and coordinating all the Member's dental care. We ask that You contact us as soon as possible if you have not selected a Primary Care Dentist so that we may assist You in selecting a Primary Care Dentist, and in making the first appointment for the Member.

Please call our Member Services Department if you have any questions about the dental coverage described in this booklet or need additional information, if you would like a new Provider Directory at no charge, or to inform us of any concerns or problems you may have with our services. The telephone number of Health Net's Member Services Department is: **1-800-977-7307 (California Relay Service (TTY) for the hearing impaired at 1-800-735-2929).**

Multilingual Services

If you or your representative prefers to speak in a language other than English, call us at **1-800-977-7307** (California Relay Service (TTY) for the hearing impaired at **1-800-735-2929**) to speak with a Health Net Member Services Representative. Our Member Services staff can help you find a dental care provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a dental care provider who meets your language needs, you can request to have an interpreter available for discussions of dental information at no charge.

This EOC booklet, as well as other informational material, has been translated into Spanish. To request translated materials, please call Health Net's Member Services at **1-800-977-7307** (California Relay Service (TTY) for the hearing impaired at **1-800-735-2929**).

Member Identification Card

All members of Health Net are given a Member Identification Card. This card contains important information regarding your dental benefits. If you have not received or if you have lost

your Member Identification Card, please call us at **1-800-977-7307** (California Relay Service (TTY) for the hearing impaired at **1-800-735-2929**) and we will send you a new card. Please show your Health Net Member Identification Card to your provider when you receive dental care.

Only the Member is authorized to obtain dental services using his or her Member Identification Card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member Identification Card, Health Net may not be able to keep you in our plan.

Definitions

Acute Condition: A medical/dental condition that involves a sudden onset of symptoms due to an illness, injury, or other medical/dental problem that requires prompt medical/dental attention and that has a limited duration.

Appropriately Qualified Dental Care Professional: A licensed dental care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.

Authorization: The requirement that certain services be approved by Health Net or your Primary Care Dentist before being provided in order to be a covered service.

Benefits (Covered Services): Dental services and supplies that a Member is entitled to receive pursuant to the terms of this Agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet if it is not Dentally Necessary, or if it is not provided by a Health Net provider with Authorization as required.

Benefit Year: The period commencing October 1, 2012 through September 30, 2013.

Complaint: A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can't get a service, treatment, or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay for

Coordination of Benefits: The method by which this program and one or more other dental plans or insurance policies will determine their respective reimbursements when a Member and the dental service(s) provided to the Member are covered by each program.

Copayment: A fee which the Plan provider may collect directly from a Member for a particular covered benefit at the time the service is rendered.

Dental Plan or Plan: Dental benefits are administered by Health Net Dental

Effective Date: The date your eligibility begins.

Emergency Care: An emergency is a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member's dental health in serious jeopardy, or

- Causing serious impairment to the member's dental functions, or
- Causing serious dysfunction of any of the member's bodily organs or parts.

Exclusion: Any dental treatment or service for which the Program offers no coverage.

Experimental or Investigational Service: Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular dental condition for which it is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC): This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Federal Poverty Income Guideline: The federal poverty income guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the "federal poverty level" (FPL).

Grievance: A written or oral expression of dissatisfaction regarding the plan and/or a provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the member's representative. Where the plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Healthy Families: The state program administered by MRMIB to provide medical, dental and vision coverage to children who meet the eligibility and income requirements and contribute a monthly family contribution.

Income Category, A, B, or C: How much you pay for the monthly premium and copayments is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-250% of the Federal Poverty Income Guideline

Limitations: A description of the number or type of services, if medically appropriate, allowed as a benefit under the program.

Managed Risk Medical Insurance Board (MRMIB): The State agency with the authority to administer the Healthy Families Program.

Member: A person who is enrolled in the Health Net Healthy Families Program and receives dental care from a plan Provider.

Member Identification Card: The identification card provided to members by Health Net that includes the member number, Primary Care Dentist information, and important telephone numbers.

Medically Necessary: Those dental treatments or supplies which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the dental condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits and alternatives.

Non-Covered Benefit: A dental procedure or service that you choose to have performed even though it is not a covered benefit

Non-Participating Provider: A provider who has not contracted with Health Net to provide services to members.

Optional Benefit: A dental benefit that you choose to have upgraded. For example, when a filling would correct the tooth but you choose to have a full crown instead.

Participating Provider: A dentist or dental facility licensed to provide covered services who or which at the time care is rendered to a Member, has a contract in effect with Health Net to provide covered services to its members.

Primary Care Dentist: A dentist, who is responsible for providing initial and primary care to members, maintains the continuity of patient care, initiates referral for specialist care, and coordinates the provision of all benefits to members in accordance with the Agreement.

Program: The Healthy Families Program.

Provider Directory: The directory of all the providers contracted with Health Net to provide services to its members.

Serious Chronic Condition: A medical condition due to a disease, illness or other medical problem or medical 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: The geographic area in the State of California where the Department of Managed Health Care has authorized Health Net to provide dental services. A map of Health Net's Service Area is located on the inside back cover of this EOC.

Urgent Care: Dental care needed to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment can not be delayed.

Member Rights and Responsibilities

As a Health Net Member, you have the right to:

- Be treated with respect and dignity.
- Choose your primary care provider from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your dental care needs, including appropriate or Medically Necessary treatment options for your condition(s), regardless of cost or regardless of whether the treatment is covered by the plan.
- Have your records kept confidential. This means we will not share your dental care information without your written approval or unless it is permitted by law.
- Voice your concerns about Health Net, or about dental services you received, to Health Net.
- Receive information about Health Net, our services, and our providers.
- Make recommendations about your rights and responsibilities.
- See your dental records.
- Get services from providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- Receive Member materials translated into your language.
- File a complaint if your linguistic needs are not met.

Your responsibilities are to:

- Give your providers and Health Net correct information.
- Understand your dental problems(s) and participate in developing treatment goals, as much as possible, with your provider.

- Always present your Member Identification Card when getting services.
- Ask questions about any dental condition and make certain that the explanations and instructions are understandable.
- Make and keep dental appointments. You should inform your provider at least 24 hours in advance when an appointment must be cancelled.
- Help Health Net maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health care coverage.
- Notify Health Net as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Health Net personnel and providers respectfully and courteously.

Accessing Care

Physical Access
Health Net has made every effort to ensure that our offices and the offices and facilities of Health Net providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at **1-800-977-7307** and we will help you find an alternate provider.

Access for the Hearing Impaired
The hearing impaired may contact us through the California Relay Service (TTY) number at **1-800-735-2929**, Monday through Friday, from 6:00 a.m. to 6:00 p.m. Between 6:00 p.m. and 6:00 a.m. and on weekends, please call the California Relay Service TTY at 711 to get the help you need.

Access for the Vision Impaired
This Evidence of Coverage (EOC) and other important plan materials will be made available in large print, for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at **1-800-977-7307**.

The Americans with Disabilities Act of 1990
Health Net complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances
If you believe the plan or its providers have failed to respond to your disability access needs, you may file a Grievance with Health Net by calling **1-800-977-7307**. If your disability access complaint remains unresolved, you may contact the:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695
The hearing impaired should call the California Relay Service at 711 (TTY).

Using the Dental Plan

Remember you can keep your dental expenses down by:

- Using only Health Net participating dentists,
- Visiting your dentist regularly for checkups,
- Following your dentist's advice about regular brushing and flossing, and
- Seeking treatment before you have a major problem.

Service Area

The Member must reside within Health Net's Service Area to be eligible to enroll and remain enrolled in Health Net. If You move out of Health Net Service Area, You must inform Health Net by calling Member Services at **1-800-977-7307** and request a transfer to another participating health plan that serves the new area in which you will reside thirty (30) days prior to the move.

Facilities Locations

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

Health Net provides Covered Dental Services through Participating Dental Groups and Participating Dentists that independently contract with Health Net to provide Covered Dental Services to Members at their dental offices. Health Net has Participating Dentists in all major dental specialties. The location and hours of service of the Participating Dental Groups and Participating Dentists are available by calling the Health Net Member Services Department at **1-800-977-7307**, or California Relay Service (TTY) **1-800-735-2929** for the hearing impaired. Emergency Dental Services are available twenty-four (24) hours a day, seven (7) days a week.

Choosing a Primary Care Dental Provider

Primary Care Dentists are dentists who are responsible for providing initial and primary care to members, maintaining the continuity of patient care, initiating referrals for specialist care, and coordinating the provision of all Benefits to members in accordance with the Agreement. You have the opportunity to choose a Primary Care Dentist from among the Participating Dental Groups and Participating Dentists listed in the Health Net Dental Provider Directory. There are a few things to consider when selecting Your Primary Care Dentist: 1) office location; 2) office hours, 3) language(s) spoken by the dentist. A dentist located near the Member's school may be most convenient, or maybe You need an office that is open on

Saturday. Perhaps you would prefer a dentist that speaks a particular language. If You listed Your choice of a Primary Care Dentist on the application form when You enrolled in the Healthy Families Program, the Program will provide the name of Your chosen Primary Care Dentist to Health Net. If You did not choose a Primary Care Dentist when You enrolled in Health Net, please find the name of the Primary Care Dentist of your choice in the Health Net Dental Provider Directory and notify Health Net's Member Services Department at **1-800-977-7307**, or California Relay Service (TTY) **1-800-735-2929** for the hearing impaired. If you need assistance selecting a Primary Care Dentist, please contact Health Net's Member Services Department.

Health Net will make sure that all Members are assigned to a Primary Care Dentist within 30 calendar days of the beginning date of coverage in the Health Net Dental Plan. If You do not notify Health Net of Your choice of a Primary Care Dentist, Health Net will assign a Primary Care Dentist to You and promptly notify You of the selection and of the opportunity to change the assigned Primary Care Dentist. Health Net will take into account geographic accessibility and language capabilities of Participating Dentists in making such assignments.

Except for Emergency Dental Services or Urgently Needed Services, You must obtain all Covered Dental Services from Your Primary Care Dentist to qualify for coverage, unless You receive prior authorization from Your Primary Care Dentist or the Dental Director or designee to receive services from a Specialist Dentist as explained in the sections that follow.

Scheduling Appointments

Whenever possible, You should call to schedule an appointment before a visit to Your Primary Care Dentist. For routine office visits, please call Your Primary Care Dentist at least 48 hours in advance to schedule an appointment. For dental health evaluation appointments, such as Your yearly dental examination, please call at least two or three weeks in advance. If You need more immediate attention, call Your Primary Care

Dentist and request the next available appointment. IF YOU NEED TO CANCEL AN APPOINTMENT, CALL YOUR PRIMARY CARE DENTIST AS FAR IN ADVANCE AS POSSIBLE, PREFERABLY 24 HOURS BEFORE THE SCHEDULED APPOINTMENT. Your dentist may charge you a $10 fee if you fail to cancel an appointment at least twenty-four (24) hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

Changing Your Primary Care Dental Provider

You can change Your Primary Care Dentist selection at any time by calling or making a written request to the Health Net Member Services Department **1-800-977-7307**.

Required Change of Primary Care Dentist

Health Net has the right to change Your selection of a Primary Care Dentist, but only upon notifying you. Health Net will promptly notify You if for any reason Your selected Primary Care Dentist is no longer available to continue providing Your dental care and will provide You with the opportunity to select another Primary Care Dentist. Health Net will also notify You of any changes in the names, locations and hours of service of the Participating Dentists and Participating Dental Groups listed in the Health Net Dental Provider Directory that materially affects Your choice or use of a Primary Care Dentist.

Continuity of Care for New Members

Under some circumstances, Health Net will provide continuity of care for new members who are receiving dental services from a non-participating dental provider when Health Net determines that continuing treatment with a Non-Participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a Non-Participating Provider if you were receiving this care before enrolling in Health Net and if you have one of the following conditions:

- An acute dental condition. Completion of covered services shall be provided for the duration of the acute condition.
- A Serious Chronic Condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Health Net in consultation with you and the Non-Participating Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Health Net.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Participating Provider to occur within 180 days of the time you enroll with Health Net.

Please contact us at **1-800-977-7307** to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

We will request that the Non-Participating Provider agree to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the Non-Participating Provider does not accept the terms and conditions, Health Net is not required to continue that provider's services.

Health Net is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Healthy Families coverage. Continuity of care does not provide

coverage for benefits not otherwise covered under this agreement.

The Health Net Utilization Management department will notify you by telephone and by mail when we have determined whether you are eligible for continuity of care. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Health Net's Grievance and Appeals Process on page 47.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-HMO-2219**; or at the TDD number for the hearing impaired, **1-877-688-9891**; or online at www.hmohelp.ca.gov.

Continuity of Care for Termination of Provider

If your primary care or other dental care provider stops working with Health Net, we will let you know by mail 60 days before the contract termination date.

Health Net will provide continuity of care for covered services rendered to you by a provider whose participation has terminated if you were receiving this care from this provider prior to the termination and if you have one of the following conditions:

- An acute dental condition. Completion of covered services shall be provided for the duration of the acute condition.
- A Serious Chronic Condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Health Net in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Health Net.

- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the terminated provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to dental disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with Health Net prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the provider's services beyond the contract termination date.

Please contact us at **1-800-977-7307** to request continuing care or to obtain a copy of our continuity of care policy. Normally, eligibility to receive continuity of care is based on your dental condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

The Health Net Utilization Management department will notify you by telephone and by mail when we have determined whether you are eligible for continuity of care. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Health Net's Grievance and Appeals Process on page 47.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-HMO-2219**; or at the TDD number for the hearing impaired, **1-877-688-9891**; or online at www.hmohelp.ca.gov.

Prior Authorization for Services
Your Primary Care Dentist will coordinate your dental care needs and, when necessary, will arrange specialty services for you. In some cases, Health Net must authorize the specialty services before you receive the services. Your Primary Care Dentist will obtain the necessary referrals and authorizations for you. Some specialty services, such as Emergency Care, do not require prior authorization before you receive the services.

If you see a specialist or receive specialty services before you receive the required Authorization, you will be responsible to pay for the cost of the treatment. If Health Net denies a request for specialty services, Health Net will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialists
Your Primary Care Dentist may refer you to another dentist for consultation or specialized treatment. Your Primary Care Dentist will submit a request to Health Net for payment authorization.

In consultation with you, your Primary Care Dentist will choose a specialist dentist from whom you may receive services. In the event that there is no Participating Provider available to perform the needed service, your provider will refer you to a Non-Participating Provider for the services after obtaining Authorization from Health Net. In the instance that there are no contracted specialty providers in your county, benefits will be provided to you as if the specialty providers were contracted with the plan.

All services must be authorized before the date the services are provided, except for services provided by your provider or for emergency dental care services. If the services are not authorized before they are provided, they will not be a covered benefit, even if the services are needed.

This is a summary of Health Net's referral policy. To obtain a copy of our policy please contact us at **1-800-977-7307** (California Relay Service (TTY) for the hearing impaired at **1-800-735-2929**).

If your request for a referral is denied, you may appeal the decision by following Health Net's Grievance and Appeal Process found on page 47.

Obtaining a Second Opinion

Sometimes you may have questions about your condition or your Primary Care Dentist's recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended procedure;
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
- Your provider's advice is not clear, or it is complex and confusing,
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results,
- The treatment plan in progress has not improved your dental condition within an appropriate period of time;
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

You should speak to your Primary Care Dentist if you want a second opinion. After you or your Primary Care Dentist has requested permission to obtain a second opinion, Health Net will authorize or deny your request in an expeditious manner. If your dental condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your

request for a second opinion will be processed within 72 hours after Health Net receives your request.

If your request to obtain a second opinion is authorized, you must receive services from plan provider within your dental network. If there is no qualified provider in your network, Health Net will authorize a second opinion from a Non-Participating Provider. You will be responsible for paying all copayments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to Health Net's Grievance and Appeals Process on page 47.

This is a summary of Health Net's policy regarding second opinions. To obtain a copy of our policy, please contact us at **1-800-977-7307**.

Utilization Review

There may be times when Your Primary Care Dentist believes it is necessary to order additional testing, evaluation or treatment by a Specialist Dentist, which requires prior authorization from the Health Net Dental Director or designee. In such a case, the Primary Care Dentist must complete a dental referral authorization request form, describing Your dental condition and the Dental Necessity for a Referral to a Specialist Dentist, and forward the form with appropriate dental record information to the Health Net Dental Department. The request is reviewed by the Dental Director or designee using specific criteria for determining Dental Necessity and based on the most current information regarding Your dental condition and current treatment methods. The Dental Director or designee may consult with a Consulting Dentist who is appropriately licensed to practice in the relevant specialty area and has the relevant training and expertise to evaluate the requested Authorization, if necessary. A decision is made for non-emergency referrals within five days to either approve or deny the request, request additional information or recommend alternative treatments.

Health Net uses written guidelines, policies and procedures based on dental necessity to review, approve, modify, or deny requests by Participating Dentists for Authorization for the provision of dental care services. These guidelines, policies and procedures help to ensure that decisions based on dental necessity are based on consistent criteria that are supported by clinical principles. Health Net discloses, or provides for the disclosure of, these guidelines, policies and procedures to its Participating Dentists, as well as to our members who request this information. Decisions to deny or modify requests for Authorization of dental services, based on dental necessity, are made only by licensed dentists or other appropriately licensed dental professionals. Health Net and Contracting Dental Groups make these decisions within the time frames required by state law.

When a requested Authorization is approved, Your Primary Care Dentist will refer You to the appropriate Specialist Dentist. You will be referred to a Specialist Dentist from within Your Primary Care Dentist's Participating Dental Group, if applicable, or to one of the independent Participating Dentists. If the specialty dental services You require are not available from any Participating Dentists, You will be referred to a Non-Participating Dentist practicing in the required specialty.

If the Authorization request is denied, and if you believe that this determination is not correct, you have the right to appeal. You or your dentist is entitled to appeal this decision, as outlined in the section of this booklet entitled "Health Net Grievance and Appeal Procedure, Review by California Department of Managed Health Care, Binding Arbitration." If You would like a more detailed description of Health Net's Criteria for Authorizing or Denying Services, please contact Health Net's Member Services Department at **1-800-977-7307**, or California Relay Service (TTY) **1-800-735-2929** for the hearing impaired. Your request may be verbal or in writing. There are two methods of appeal: standard appeal and expedited appeal. Please refer to Page 47 for more details.

Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed. Health Net covers urgent care services any time you are outside our Service Area or on nights and weekends when you are inside our Service Area. To be covered by Health Net, the urgent care service must be needed because the illness or injury will become much more serious, if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Dentist about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed.

To obtain Urgent Care when you are **inside** Health Net's Service Area on nights and weekends, please call the Primary Care Dentist's 24-hour emergency number printed on your Health Net I.D. Card, or contact Health Net Member Services at **1-800-977-7307** and follow the instructions provided.

To obtain Urgent Care when you are **outside** Health Net's services area, please call the Primary Care Dentist's 24-hour emergency number printed on your Health Net I.D. Card, or contact Health Net Members Services at **1-800-977-7307** and follow the instructions provided.

Getting Emergency Services

An emergency is a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member's dental health in serious jeopardy, or
- Causing serious impairment to the member's dental functions, or
- Causing serious dysfunction of any of the member's bodily organs or parts.

Emergency dental care services are available to you twenty-four (24) hours a day, both inside and outside our Service Area. If you have a dental emergency, you should call Your Primary Care Dentist and follow the instructions provided. The 24-hour Emergency telephone number of Your Primary Care Dentist is printed on Your Member Identification Card. You may also call Health Net Member Services at **1-800-977-7307**. Depending on Your dental condition, You may be scheduled for an urgent visit at Your Primary Care Dentist's office or other Participating Dentist, or You may be directed to a hospital emergency room.

If Your Emergency is so severe that You cannot take time to call Your Primary Care Dentist or the Health Net, call **911** or go immediately to the nearest hospital emergency room for care. Do whatever is fastest wherever You are, then call or have someone acting on Your behalf call Your Primary Care Dentist or Health Net within 24 hours after the commencement of the Emergency or as soon as possible.

ALWAYS CARRY YOUR MEMBER IDENTIFICATION CARD WITH YOU AND PRESENT IT WHEN SEEKING EMERGENCY DENTAL SERVICES.

What to Do If You Are Not Sure If You Have an Emergency
If you are not sure whether you have an emergency or require Urgent Care, please call the Primary Care Dentist's 24-hour emergency number printed on your Health Net I.D. Card, or call Health Net Member Services at **1-800-977-7307**, 24 hours per day, 7 days per week. Current contracted provider information may be found on our website, www.hndental.com, or by calling our Member Services Department.

Non-Covered Services
Health Net does not cover dental services that are received in an emergency or Urgent Care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or Urgent Care situation did not exist. You will be responsible for all charges related to these services.

Follow-Up Care
After receiving any emergency or urgent care services, you will need to call your Primary Care Dentist for follow-up care.

Copayments
You will be required to pay a small amount of money for some services. This is called a Copayment. You are responsible to pay the Copayment to the dental provider at the time services are provided. There are no copayments for the preventive and diagnostic services listed in the Benefits section of this EOC. Additionally, there are no copayments for members who are determined by the Healthy Families Program to be American Indians or Alaska Natives. For information pertaining to Copayment waivers for American Indians or Alaskan Natives, please refer to the Healthy Families Program Handbook or contact the Healthy Families Program at **(800) 880-5305**.

The annual Copayment maximum that you have in your Healthy Families health plan does not apply to dental benefits. No deductibles are charged for dental benefits.

Member Liabilities
Generally, the only amount a member pays for covered services is the required copayment.

You may have to pay for services you receive that are NOT covered services, such as:

- non-emergency services received in the emergency room;
- non-emergency or non-urgent services received outside of Health Net Dental's service area if you did not get authorization from Health Net Dental before receiving such services;
- specialty services you receive if you did not get a required referral or authorization from Health Net Dental before receiving such services (see page 17 Prior authorization for services);

- services from a non-participating provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, emergency services, urgent services outside of the plan's service area, or specialty services approved by the plan (see page 11, choosing a primary care dental provider); or
- services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by Health Net Dental.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at (800) 977-7307 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Health Net Dental is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If Health Net Dental does not pay a non-participating provider for covered services, you do not have to pay the non-participating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet. The non-participating provider must bill Health Net Dental, not you, for any covered service. But remember, services from a non-participating provider are not "covered services" unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider, whether participating or non-participating, contact the Health Net Dental member services department at (800-977-7307).

Missed Appointments

Your dentist may charge you a $10.00 fee if you fail to cancel an appointment at least twenty-four (24) hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

Dental Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPT OF COVERED BENEFITS AND LIMITATIONS.

NOTE: Members in the Income Category A shall pay no more than $5 copayment for applicable covered services as described in this Benefits Section of the EOC/DF.

Benefits*	**Services**	**Cost to Member (copayment)** *Income Category A*	**Cost to Member (copayment)** *Income Categories B & C*
Diagnostic and Preventive Care Services	Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Space Maintainers, Dental sealant treatments.	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Restorative Dentistry (Fillings)	Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction with a restoration, Sedative base and sedative fillings.	No copayment	No copayment
Oral Surgery	Extractions, including surgical extractions, Removal of impacted teeth, Biopsy of oral tissues, Alveolectomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of	No copayment, except • $5 copayment for the removal of impacted teeth for a bony impaction • $5 copayment per root	No copayment, except • $10 copayment for the removal of impacted teeth for a bony impaction • $10 copayment per root recovery

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
	mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure).	recovery	
Endodontic	Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests.	No copayment, except • $5 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $5 copayment per root for an apicoectomy	No copayment, except • $10 copayment per canal for root canal therapy or retreatment of previous root canal therapy • $10 copayment per root for an apicoectomy

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Periodontics	Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.	No copayment, except • $5 copayment per quadrant for osseous or muco-gingival surgery	No copayment, except • $10 copayment per quadrant for osseous or muco-gingival surgery
Crown and Fixed Bridge	Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast**,** porcelain baked with metal, or plastic processed	No copayment, except • $5 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $5	No copayment, except • $10 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $10 copayment per pontic.

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
	to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.	copayment per pontic. • The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.	• The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.
Removable Prosthetics	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates.	No copayment, except: ▪ $5 copayment for a complete maxillary or mandibular denture ▪ $5 copayment for partial acrylic upper or lower denture with clasps ▪ $5	No copayment, except: ▪ $10 copayment for a complete maxillary or mandibular denture ▪ $10 copayment for partial acrylic upper or lower denture with clasps ▪ $10

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
		copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $5 copayment for removable unilateral partial denture ▪ $5 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $5 copayment for denture duplication	copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles ▪ $10 copayment for removable unilateral partial denture ▪ $10 copayment for reline of upper, lower or partial denture when performed by a Laboratory ▪ $10 copayment for denture duplication

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Other Benefits	Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.	No copayment	No copayment
Orthodontia Services	Not a Healthy Families Program covered benefit. Services are	Not applicable	Not applicable

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
	provided to members under the age of 19 through the California Children's Services Program (CCS) if the Member meets the eligibility requirements for medically necessary orthodontia coverage.		
Deductibles	No deductibles will be charged for covered benefits under this program.		
Lifetime Maximums	No lifetime maximum limits on benefits apply under this program.		

* Benefits are provided if the Plan determines them to be Dentally Necessary.

Benefits

This section lists the dental benefits and services you are allowed to obtain through Health Net when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exception and limitations listed here and in the Exclusions section of this EOC.

NOTE: Members in the Income Category A shall pay no more than $5 copayment for applicable covered services as described in this Benefits Section of the EOC/DF.

Diagnostic and Preventive Benefits

Cost to Member

No Copayment

Description

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Limitations

Roentgenology (x-rays) is limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis

- Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months
- Panoramic film x-rays are limited to once every 24 consecutive months
- Prophylaxis services (cleanings) are limited to two in a 12-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Cost to Member

No Copayment

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are noncosmetic
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery

Cost to Member

No Copayment, except:

- $5.00 or $10.00 Copayment for the removal of impacted teeth for a bony impaction (no Copayment for the removal of a soft tissue impaction)
- $5.00 or $10.00 Copayment per root recovery

Description

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontic

Cost to Member

No Copayment, except:

- $5.00 or $10.00 Copayment per canal for root canal therapy
- $5.00 or $10.00 Copayment per canal for retreatment of previous root canal
- $5.00 or $10.00 Copayment per canal for an apicoectomy when performed as a separate procedure

Description

Endodontic benefits include:

- Direct pulp capping

- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Cost to Member

No Copayment, except:

- $5.00 or $10.00 Copayment per quadrant for osseous or muco-gingival surgery

Description

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or mucogingival surgery

Limitation

Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown and Fixed Bridge

Cost to Member

No Copayment, except:

- $5.00 or $10.00 Copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.
- $5.00 or $10.00 Copayment per pontic.
  The Copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitations

The crown benefit is limited as follows:

- Replace of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an Optional Benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either

fractured or decayed to the extent that they will not hold a filling.

- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The Program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Cost to Member

No Copayment, except:

- $5.00 or $10.00 Copayment for a complete maxillary denture

- $5.00 or $10.00 Copayment for a complete mandibular denture
- $5.00 or $10.00 Copayment for partial acrylic upper or lower denture with clasps
- $5.00 or $10.00 Copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles
- $5.00 or $10.00 Copayment for removable unilateral partial denture
- $5.00 or $10.00 Copayment for reline of upper, lower or partial denture when performed by a Laboratory
- $5.00 or $10.00 Copayment for denture duplication

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 36 consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to

satisfactorily restore an arch, the patient will be responsible for all additional charges.

- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an Optional Benefit
- Stayplates are a benefit only when used as anterior space maintainers for children.

Other Benefits

Cost to Member

No Copayment

Description

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Orthodontic Benefits
Orthodontic treatment is not a benefit of this Dental Plan. However, orthodontic treatment may be provided by the California Children's Services (CCS) program if the Member meets the eligibility requirements for Medically Necessary orthodontia coverage under the CCS program. For more information about the CCS program, see "Coordination of Services" on page 41.

Coordination of Services

California Children's Services (CCS)
As part of the services provided through the HFP, members needing specialized dental care may be eligible for services through the CCS program.

CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the Healthy Families Program are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the county CCS office.

If a member's primary dental care provider suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. Health Net can assist with this referral. Health Net will also make a referral to CCS when the plan suspects or identifies a possible CCS condition. The CCS program will determine whether the member's condition is eligible for CCS services.

If the CCS program determines that the condition is a CCS eligible condition, and CCS Program is providing services to treat the eligible condition, the member will remain enrolled in

the Healthy Families Program. He or she will be referred to the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions.

Health Net will continue to provide primary dental care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. Health Net will also work with the CCS program and providers to coordinate care provided by both the CCS program and Health Net. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary dental services from Health Net. In addition, Health Net is responsible for all covered services if CCS does not authorize or does not actually provide those specific services.

Although all children enrolled in the HFP are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member's parents or legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling Health Net's Member Services toll-free at **1-800-977-7307** or by calling the local county CCS program as follows:

County	CCS Telephone No.
Alameda	510-208-5970
El Dorado	530-621-6128
Fresno	559-445-3300
Imperial	760-482-4432
Kern	661-635-2800
Kings	559-584-1401
Los Angeles	800-288-4584
Madera	559-675-7893
Marin	415-473-6877
Merced	209-381-1114
Monterey	831-755-4747
Napa	707-253-4391
Orange	714-347-0300
Riverside	951-358-5401
Sacramento	916-875-9900
San Benito	831-637-5367
San Bernardino	909-387-8400
San Diego	619-528-4000
San Francisco	415-575-5700
San Joaquin	209-953-3600
Santa Clara	408-793-6200
Santa Cruz	831-763-8900
Sonoma	707-565-4500
Stanislaus	209-558-7515
Tulare	559-685-2533
Ventura	805-981-5281

Excluded Benefits

The following dental benefits are excluded under the plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
5. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
6. Dental conditions arising out of and due to a Member's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
7. Hospital charges of any kind.
8. Major surgery for fractures and dislocations.
9. Loss or theft of dentures or bridgework.
10. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

11. Any service that is not specifically listed as a covered benefit.
12. Malignancies.
13. Dispensing of drugs not normally supplied in a dental office.
14. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
15. The cost of precious metals used in any form of dental benefits.
16. The surgical removal of implants.
17. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Dentally Necessary, or his or her panel provider is a pedodontist/pediatric dentist. Note: There is a $5.00 Copayment for children under six years of age, who are unable to be treated by their panel provider and who have been referred to a pedodontist/pediatric dentist.
18. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan providers to the courtesy extended you by our telephone representatives.
If you have questions about the services you receive from a Plan provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call Health Net's Member Service at **1-800-977-7307** (California Relay Service (TTY) for the hearing impaired at **1-800-735-2929**).

Grievance
You may file a Grievance with Health Net at any time. You can obtain a copy of Health Net's Grievance Policy and Procedure by calling our Member Service 1-800-977-7307. To begin the Grievance process, you can call, write, or fax the Plan at:

Health Net Dental
c/o Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110
1-800-977-7307
California Relay Service (TTY) at 1-800-735-2929
Fax: (949) 223-0011

Health Net will acknowledge receipt of your Grievance within five (5) days and will send you a decision letter within thirty (30) days. If your Grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that Health Net expedite its Grievance review. Health Net will evaluate your request for an expedited review and, if your Grievance qualifies as an urgent Grievance, we will process your appeal within three (3) days from receipt of your request.

You are not required to file a Grievance with Health Net before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a Grievance with Health Net in which you ask for an expedited review, Health Net will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your Grievance involving an imminent and serious threat to health, and
2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the Grievance no later than 72 hours from receipt of your request to expedite review of your Grievance.

Independent Medical Review

If dental care that is requested for you is denied, delayed or modified by Health Net or a Plan provider, you may be eligible for an Independent Medical Review (IMR). The IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, Health Net will provide coverage for the dental services.

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we

deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in Health Net's Grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-800-977-7307** and use Health Net'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 Health Net, or a grievance that remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for 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 a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site

http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Health Net's Grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law**.**

Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law

will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce

any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that State or Federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

General Information

Coordination of Benefits

When a primary dental benefit plan is coordinating its benefits with one or more secondary dental benefits plans, it shall pay the maximum amount required by its contract with the enrollee or subscriber.

A health care service plan covering dental services or a specialized health care service plan contract covering dental services, when acting as a secondary dental benefit plan, shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

This Dental Plan coverage is not designed to duplicate any dental benefits. Coverage provided under this Program is secondary to all other coverage, except Denti-Cal. Benefits

paid under this Program are determined after Benefits have been paid as a result of a member's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental care service plan, Health Net shall provide services at the time of need, and the Member or member's legal guardian will cooperate to assure that Health Net is reimbursed for such Benefits.

By enrolling in Health Net each Member agrees to complete and submit to Health Net such consents, releases, assignments and any other document reasonably requested by Health Net in order to assure and obtain reimbursement and to coordinate coverage with other dental plans or insurance policies. The payable benefits will be reduced when Benefits are available to a Member under such other plan or policy whether or not claim is made for the same.

The fact that a Member has double coverage under Health Net will in no way reduce member's obligation to make all required copayments.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all Benefits to which you are entitled. For further information, contact Health Net's Member Service department.

Third Party Recovery Process and Member Responsibilities
The Member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the Member is made whole for all other damages resulting from the wrongful act or omission before Health Net is entitled to reimbursement, Member shall:

- Reimburse Health Net for the reasonable cost of services paid by Health Net to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and

- Fully cooperate with Health Net's effectuation of its lien rights for the reasonable value of services provided by the Health Net to the extent permitted under California Civil Code section 3040. Health Net's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

Health Net shall be entitled to payment, reimbursement, and subrogation in third party recoveries and Member shall cooperate to fully and completely effectuate and protect the rights of Health Net including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers' Compensation
If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services provided by Health Net will provide the benefits of this Agreement at the time of need. The Member will agree to provide Health Net with a lien to the extent of the reasonable value of the services provided by the Health Net. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, members agree to cooperate in protecting the interest of Health Net under this provision and to execute and to deliver to Health Net or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of Health Net or its nominee. Members also agree to fully cooperate with Health Net and not take any action that would prejudice the rights of Health Net under this provision.

Limitations of Other Coverage
This dental coverage is not designed to duplicate any Benefits to which members are entitled under government programs, including CHAMPUS, Medi-Cal or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to Health Net such consents, releases, assignments, and other documents reasonably requested by Health Net or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

Provider Payment
Health Net contracts with independent Participating Dental Groups and individual dentists to provide Covered Dental Services to Members. The Participating Dental Groups, in turn, employ or contract with individual dentists. Most of Health Net's Participating Dental Groups receive an agreed upon monthly payment from Health Net to provide Covered Dental Services to Members. This monthly payment may be a fixed dollar amount for each Member received by Health Net. The monthly payment typically covers professional services directly provided by the Participating Dental Group, and may also cover certain Referral services. Health Net also contracts directly with individual Participating Dentists to provide Covered Dental Services who are compensated either on a monthly prepayment or fee-for-service basis.

If the Member is referred to a Specialist Dentist, the Specialist Dentist is paid on a fee-for-service basis by Health Net. Health Net does not offer any bonuses or incentives to Participating Dentists.

You may obtain additional information on Health Net's compensation arrangements by contacting Health Net or your Participating Dental Group.

Reimbursement Provisions – If You Receive a Bill
If for some reason you are billed for Covered Dental Services, submit the bill as soon as reasonably possible to:

Health Net Dental Claims Department
P.O. Box 26110
Santa Ana, CA 92799-6110

If the bill is for Covered Dental Services which have been authorized by Your Primary Care Dentist, the bill will be paid on Your behalf. However, if the bill is for non-Covered Dental Services, the bill will not be paid by Health Net and will remain Your responsibility.

You must submit a claim form to Health Net when You request reimbursement for the cost of Emergency Dental Services or Urgently Needed Services. Claim forms are available from the Health Net Member Services Department. Claims must be submitted to the Health Net Claims Department (at the address listed above) within 60 days or as soon as reasonably possible after the Emergency Dental Services or Urgently Needed Services are rendered. Be prepared to give as much information as possible, such as the date of the service, amount of the bill, and name and address of the provider, and any copies of bills You received.

You will be reimbursed for an approved Emergency Services claim within 45 days of the date Your claim was received, unless additional information is needed. If Your claim is denied, You will receive written notice of the decision from Health Net, including information about the reason for the denial of the claim and Your right to appeal the decision through Health Net's Grievance procedure.

Notifying You of Changes in the Plan
Throughout the year we may send you updates about changes in the Plan. This can include updates for the Provider Directory, handbook, and evidence of coverage. We will keep you

informed and are available to answer any questions you may have. Call us toll-free **1-800-977-7307** if you have any questions about changes in the Plan.

Privacy Practices

Maintaining the confidentiality of electronic and paper records and other communications regarding your health care is of primary importance to Health Net.

An Important Message About the Confidentiality of Your Dental Records

With the advent of electronic means of communication between health plans, hospitals and doctors, concerns have been raised about ensuring that Member information remains confidential and is looked at only by the professionals who provide care to members and those who pay for the services received.
Health Net shares those concerns. At Health Net we have many safeguards in place to ensure that Member information remains confidential. We continue to strive to meet the latest standards to improve our confidentiality-protection systems. Additionally, Health Net tracks information regarding Member concerns about inappropriate release of confidential information. Confidentiality standards such as limited access to data, limited access to personal medical records and appeal decisions, as well as consent and disclosure of medical information continue to be reviewed and revised consistent with industry accepted practices and State and Federal laws.

Who Has Access to My Dental Information?

It is the policy of Health Net not to share any specific or identifying dental information with any person who is not directly concerned with your care or involved in the payment of care, without you or your doctor's written consent, except as allowed under the California Civil Code. For example, information may be disclosed without your consent to public health agencies, worker's compensation carriers, the coroner, medical examiners and funeral directors, health oversight agencies, peer review organizations, authorized federal offices for national security purposes of special investigations, and to

legal entities in lawsuits and disputes. Health Net maintains the standards set forth in the Confidentiality of Medical Information Act. Both our staff, who are required to sign confidentiality agreements, and our providers, who are contractually required to abide by these requirements, safeguard the privacy of your dental information. A current, valid authorization from you is required before information is released in response to employer requests for access to or release of information from dental records, except as provided under workers' compensation.

Can I Obtain a Copy of My Dental Records?
Yes. Members may request a copy of all or part of their dental records by completing an Authorization to Release Medical Information form. Upon receipt of this form, the member's request will be processed, usually within 5 business days. A nominal fee may be charged to the Member for access and copying of dental information.

Additional Important Information
Members may obtain a copy of the Health Net's policy and procedure regarding Confidentiality by contacting our Member Services Department at **1-800-977-7307**.

Health Net's confidentiality policy and procedure contains detailed information regarding:

- What is included in a member's routine consent
- Member's access to personal records
- Protection of privacy in all settings
- Use of measurement data
- Policy of information for employers
- Right to approve release of information (use of special consents)

Please contact our Member Services Department at **1-800-977-7307** with any questions or concerns you have.

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (http://www.organdonor.gov) has additional information on donating your organs and tissues.

Plan's Service Area Map

Health Net Dental
provides Healthy Families Program
coverage in 26 counties.

Note: Not all counties have full coverage.