DENTAL AND VISION
COVERAGE

INDIVIDUAL & FAMILY PLANS
Health coverage made easy.

Effective July 1, 2005

Health Net®
A Better Decision

DENTAL AND VISION PPO PLUS[1] COVERAGE FROM HEALTH NET

Health Net offers a full line of dental and vision benefits administered through SafeGuard Health Plans, Inc. and Eyemed Vision Care, LLC.

This optional coverage is available as a package to you with no deductibles.

Dental benefits include:

- Choose your own dental providers
- Available fee schedule shows the maximum allowable amount so you know costs up front
- $50 deductible waived for diagnostic and preventative services

Vision benefits include:

- The flexibility of an out-of-network provider option (PPO)
- Single, bifocal and lenticular lenses covered at 100% in-network
- Freedom to take your prescription to a vision PPO provider

1 A Health Net "PPO Plus" plan is a Health Net PPO plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage. Health Net Dental and Vision plans underwritten by Health Net Life Insurance Company.

MONTHLY PREMIUMS AS LOW AS $25

Subscriber	$25
Subscriber & spouse	$50
Subscriber & child	$50
Subscriber & children	$75
Family	$100

HOW TO APPLY

To apply for dental and vision coverage with Health Net:

- Call 1-800-909-3447, or
- Contact your Health Net authorized agent.

BENEFITS AND COVERAGES

DENTAL

Dental coverage for PPO Plus plans is underwritten by Health Net Life Insurance Company and administered by SafeGuard Health Plans, Inc. This benefit is included with Health Net PPO Plus plans only.

Dental benefits are for individuals and families who want quality, yet affordable, dental coverage with the freedom to go to any licensed dentist or dental specialist. Dental benefits are not subject to health plan deductible requirements, and do not accumulate toward the out-of-pocket maximum responsibility.

A choice of providers

Under the Dental Plan, covered services can be obtained from any licensed dentist of your choice to receive your dental care. No referral is necessary to see a specialist. All covered services are reimbursed up to a maximum allowed fee as shown in the Schedule of Benefits.

Deductibles

At the time you receive services, you will be required to satisfy the calendar year deductible. Deductibles are paid to your dentist at the time care is rendered. The Dental Plan has a deductible of $50. The deductible amount will apply separately to you and each of your dependents. This deductible is waived for diagnostic and preventive services.

Maximum allowed fee

The maximum allowed fee is the maximum amount Health Net Life will pay for covered services (please refer to the Schedule of Benefits). You will be responsible for your deductible and the dentist's normal charges in excess of the maximum allowed fee.

Maximum benefit limit

The calendar year maximum benefit for the Dental Plan is $1,000. The calendar year maximum benefit will apply separately to you and each of your dependents. This is the maximum amount Health Net Life will pay for covered services per calendar year.

Dental Member Services

If you have a question about the benefits of the Dental Plan, simply call Health Net Dental Customer Service at 1-800-880-8113.

VISION

Vision coverage for PPO Plus Plans is underwritten by Health Net Life Insurance Company and administered by Eyemed Vision Care, LLC. Image Vision benefits are for individuals and families who want quality, yet affordable, vision coverage. Vision benefits are not subject to health plan deductible requirements, and do not accumulate toward the maximum calendar year copayment responsibility.

Copayments

At the time you receive services, you will be required to pay the copayment amounts listed in the Schedule of Benefits. The copayment amounts will apply separately to you and each of your dependents.

Maximum benefit retail allowances

After the copayment amounts are satisfied each calendar year, Health Net Life will pay for benefits for covered charges up to the maximum benefit retail allowance, as shown in the Schedule of Benefits. You will be responsible for any charges in excess of the maximum benefit allowance.

A choice of providers

Under the Image Vision Plan, covered services can be obtained from Preferred or Non-preferred Vision Providers. However, if you receive vision services or materials from a Preferred Vision Provider, covered expenses will be paid at a higher level. Certain services or materials may be payable only if obtained from a Preferred Vision Provider, as indicated in the Schedule of Benefits. Preferred Vision Providers have agreed to accept Health Net Life's determination and payment of negotiated rates for covered charges. You will be required to pay applicable copayments and coinsurance amounts and all charges in excess of the maximum benefit retail allowance.

If services or materials are received from Non-preferred Vision Providers, Health Net Life will reimburse covered charges at the maximum benefit retail allowance for covered services, as indicated in the Schedule of Benefits.

Obtaining vision benefits

At the time of your visit, you will be required to pay applicable copayments and coinsurance amounts and all charges in excess of the maximum benefit retail allowances as shown in the Schedule of Benefits.

Second pair

We recognize that you may prefer to have a second pair of frames and lenses as a convenience. The first pair of frames and corrective lenses are covered by the plan; however, we have negotiated with Preferred Vision Providers to extend a 20 percent discount from their reasonable and customary fees for a second pair of frames and corrective lenses (including, but not limited to, prescription sunglasses, Video Display Terminal prescription in lieu of bifocals, safety glasses, occupational or recreational glasses) at the same time as the first pair of frames and corrective lenses. Of the two pairs of frames and corrective lenses, the more expensive pair will be defined as the "first pair" while the less expensive pair will be considered the "second pair."

Preferred vision providers

To get a list of Preferred Providers in your area, simply log on to www.healthnet.com *> Search Our Doctor Network*. Health Net Life will pay the Preferred Vision Provider any covered charges without you having to submit a claim.

Non-preferred vision providers

If you receive benefits from a Non-preferred Vision Provider, you will be responsible for the difference in the maximum benefit retail allowance and the provider's normal fee. You will be required to pay the full cost for the covered service, then submit a claim for reimbursement.

Vision Member Services

If you have a question about the benefits of the Image Vision Plan, or need assistance in selecting a Preferred Vision Provider, just call Health Net Vision's Member Services at 1-866-392-6058.

SCHEDULE OF BENEFITS FOR DENTAL CARE PROVIDED WITH PPO PLUS PLANS

THIS MATRIX IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Diagnostic procedures	
D0120	Periodic oral examination	$13
D0140	Limited oral evaluation, problem focused	$17
D0150	Comprehensive oral examination	$17
D0210	Intraoral – complete series including bitewings *(FMX)*	$40
D0220	Intraoral – periapical, first film	$10
D0230	Intraoral – periapical, each additional film	$7
D0240	Intraoral – occlusal film	$11
D0250	Extraoral – first film	$13
D0260	Extraoral – each additional film	$10
D0270	Bitewing – single film	$10
D0272	Bitewings – two films	$15
D0274	Bitewings – four films	$21
D0330	Panoramic film	$31
	Preventive procedures	
D1110	Dental prophylaxis – adult	$32
D1120	Dental prophylaxis – children to age 14	$25
D1201	Topical application of fluoride *(including prophylaxis – child)*	$25
D1203	Topical application of fluoride *(excluding prophylaxis – child)*	$17
D1351	Sealant, per tooth	$4
D1510	Space maintainer – fixed, unilateral	$61
D1515	Space maintainer – fixed, bilateral	$61
D1520	Space maintainer – removable, unilateral	$72
D1525	Space maintainer – removable, bilateral	$72
	Restorative procedures	
D2140	Amalgam – one surface, primary	$19
D2150	Amalgam – two surfaces, primary	$24
D2160	Amalgam – three surfaces, primary	$29
D2161	Amalgam – four or more surfaces, primary	$35
D2140	Amalgam – one surface, permanent	$22
D2150	Amalgam – two surfaces, permanent	$28
D2160	Amalgam – three surfaces, permanent	$33
D2161	Amalgam – four or more surfaces, permanent	$39
D2330	Resin – one surface, anterior	$19
D2331	Resin – two surfaces, anterior	$24
D2332	Resin – three surfaces, anterior	$29
D2335	Resin – four or more surfaces or involving incisal angle, anterior	$35
D2390	Resin-based composite crown – anterior, (primary teeth)	$31

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Restorative procedures (continued)	
D2510	Inlay metallic, one surface[1]	$66
D2520	Inlay metallic, two surfaces[1]	$72
D2530	Inlay metallic, three or more surfaces[1]	$83
D2542	Onlay – metallic, two surfaces[1]	$110
D2543	Onlay – metallic – three surfaces[1]	$110
D2544	Onlay – metallic – four or more surfaces[1]	$110
D2710	Crown – resin-based composite (indirect)[1]	$127
D2720	Crown resin with high noble metal[1]	$154
D2721	Crown resin with predominantly base metal[1]	$154
D2722	Crown resin with noble metal[1]	$154
D2740	Crown porcelain/ceramic substrate[1]	$248
D2750	Crown porcelain fused to high noble metal[1]	$248
	Diagnostic procedures	
D2751	Crown porcelain fused to predominantly base metal[1]	$248
D2752	Crown porcelain fused to noble metal[1]	$248
D2790	Crown full cast high noble metal[1]	$154
D2791	Crown full cast predominantly base metal[1]	$154
D2792	Crown full cast noble metal[1]	$154
D2794	Crown – titanium	$154
D2910	Recement inlay, onlay or partial coverage restoration	$11
D2915	Recement cast or prefabricated post and core	$11
D2920	Recement crown	$11
D2930	Prefabricated stainless steel crown, primary tooth	$31
D2931	Prefabricated stainless steel crown, permanent tooth	$31
D2950	Core buildup, including any pins[1]	$22
D2952	Cast post and core in addition to crown[1]	$28
D2953	Each additional cast post – same tooth[1]	$28
D2954	Prefabricated post and core in addition to crown[1]	$28
D2957	Each additional prefabricated post – same tooth[1]	$28
	Endodontic procedures	
D3110	Pulp cap – direct, excluding final restoration	$10
D3120	Pulp cap – indirect, excluding final restoration	$17
D3220	Therapeutic pulpotomy, excluding final restoration – removal of pulp coronal to the dentinoenamel junction and application of medicament, primary teeth only	$13
D3310	Root canal anterior, excluding final restoration[2]	$121

[1] Subject to six-month waiting period

[2] Subject to three-month waiting period

Summary of dental benefits (continued)

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Endodontic procedures (continued)	
D3320	Root canal bicuspid, excluding final restoration[2]	$143
D3330	Root canal molar, excluding final restoration[2]	$193
D3346	Retreatment of previous root canal therapy – anterior[2]	$121
D3347	Retreatment of previous root canal therapy – bicuspid[2]	$143
D3348	Retreatment of previous root canal therapy – molar[2]	$193
D3410	Apicoectomy/periradicular surgery, anterior[2]	$66
D3421	Apicoectomy/periradicular surgery, bicuspid *(first root)*[2]	$88
D3425	Apicoectomy/periradicular surgery, molar *(first root)*[2]	$88
D3426	Apicoectomy/periradicular surgery *(each additional root)*[2]	$28
D3430	Retrograde filling, per root[2]	$17
	Periodontic procedures	
D4210	Gingivectomy or gingivoplasty, per quadrant[2]	$99
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces – per quadrant	$44
D4260	Osseous surgery *(including flap entry and closure)* – four or more contiguous teeth or bounded teeth spaces, per quadrant[2]	$176
D4261	Osseous surgery *(including flap entry and closure)* – one to three contiguous teeth or bounded teeth spaces – per quadrant[2]	$44
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant[2]	$44
D4342	Periodontal scaling and root planning – one to three teeth, per quadrant[2]	$23
	Prosthodontics – removable	
D5110	Complete upper denture[1]	$264
D5120	Complete lower denture[1]	$264
D5130	Immediate upper denture[1]	$264
D5140	Immediate lower denture[1]	$264
D5211	Upper partial – resin base[1]	$132
D5212	Lower partial – resin base[v]	$132
D5213	Upper partial – cast metal base with resin saddles[1]	$264
D5214	Lower partial – case metal base with resin saddles[1]	$264
D5281	Removable unilateral partial denture – one piece cast metal[1]	$88
D5410	Adjust complete denture, upper	$11
D5411	Adjust complete denture, lower	$11
D5421	Adjust partial denture, upper	$11
D5422	Adjust partial denture, lower	$11
D5510	Repair broken complete denture base	$22

[1] Subject to six-month waiting period

[2] Subject to three-month waiting period

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Prosthodontics – removable (continued)	
D5520	Replace missing or broken teeth complete denture, each tooth	$8
D5610	Repair resin saddle or base	$22
D5640	Replace tooth on denture, no other repair, each tooth	$8
D5650	Add tooth to partial denture to replace extracted tooth, not involving clasps	$9
D5660	Add clasp or rest to existing partial denture	$9
D5710	Rebase complete upper denture	$28
D5711	Rebase complete lower denture	$28
D5720	Rebase partial upper denture	$28
D5721	Rebase partial lower denture	$28
D5730	Reline upper complete denture, chairside	$28
D5731	Reline lower complete denture, chairside	$28
D5740	Reline upper partial denture, chairside	$28
D5741	Reline lower partial denture, chairside	$28
D5750	Reline upper complete denture, laboratory	$61
D5751	Reline lower complete denture, laboratory	$61
D5760	Reline upper partial denture, laboratory	$61
D5761	Reline lower partial denture, laboratory	$61
D5820	Interim partial denture, anterior stayplate *(upper)*[1]	$50
D5821	Interim partial denture, anterior stayplate *(lower)*[1]	$50
	Prosthodontics – fixed	
D6210	Pontic – cast high noble metal[1]	$77
D6211	Pontic – cast predominantly base metal[1]	$77
D6212	Pontic – cast noble metal[1]	$77
D6214	Pontic – titanium	$77
D6240	Pontic, porcelain fused to high noble metal[1]	$138
D6241	Pontic, porcelain fused to predominantly base metal[1]	$138
D6242	Pontic, porcelain fused to noble metal[1]	$138
D6250	Pontic, resin with high noble metal[1]	$94
D6251	Pontic, resin with predominantly base metal[1]	$94
D6252	Pontic, resin with noble metal[1]	$94
D6930	Recement fixed partial *(bridge)*	$17
	Oral surgery	
D7111	Extraction, coronal remnants – deciduous tooth[2]	$22
D7140	Extraction, erupted tooth or exposed root *(elevation and/or forceps removal)*[2]	$22
D7140	Extraction, erupted tooth or exposed root *(elevation and/or forceps removal)*, each additional tooth when performed on the same visit as the first extraction[2]	$17
D7210	Surgical removal of erupted tooth[2]	$33
D7220	Removal of impacted tooth, soft tissue[2]	$44

Summary of dental benefits (continued)

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Oral surgery (continued)	
D7230	Removal of impacted tooth, partially bony[2]	$55
D7240	Removal of impacted tooth, completely bony[2]	$66
D7241	Removal of impacted tooth, completely bony, complications[2]	$66
D7310	Alveoloplasty in conjunction with extractions, per quadrant[2]	$22
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$11
D7320	Alveoloplasty not in conjunction with extractions, per quadrant[2]	$44
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant[2]	$22
D7471	Removal of lateral exostosis *(maxilla or mandible)*, per site[2]	$61

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
	Oral surgery (continued)	
D7472	Removal of torus palitinus	$61
D7473	Removal of torus mandibularis	$61
D7485	Surgical reduction of osseous tuberosity	$61
D7970	Excision of hyperplastic tissue, per arch[2]	$55
	Adjunctive general services	
D9220	General anesthesia, first 30 minutes	$28
D9310	Specialist consultation *(other than treatment provider)*	$20
D9430	Office visit, regular hours, no other service	$20
D9440	Office visit, after hours, no other service	$20

[1] Subject to six-month waiting period

[2] Subject to three-month waiting period

IMAGE VISION SCHEDULE OF BENEFITS

THIS SCHEDULE OF BENEFITS IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

COVERED VISION BENEFITS	PREFERRED PROVIDER IN-NETWORK	NON-PREFERRED PROVIDER OUT-OF-NETWORK
	Percentage of covered charges or the maximum benefit retail allowance when received from a Preferred Provider.	The maximum benefit retail allowances the plan pays when received from a Non-Preferred Provider.
	You pay the remaining coinsurance or amounts in excess of the maximum benefit retail allowances shown below.	You pay the difference in the maximum benefit retail allowance shown below and the provider's normal fee.
Examination copayment *(per member)*	$10	$10
Materials copayment *(per member)*	$25	$25
Vision examination One complete visual examination every 12 consecutive months	100% of negotiated rate *(includes dilation)*	Plan pays up to $45 *(dilation not included)*
Frames One frame every 24 months	Plan allows up to a maximum $85 retail benefit allowance	Plan allows up to a maximum $45 retail benefit allowance
Standard corrective lenses Once every 24 consecutive months	100% of negotiated rate for standard single vision, bifocal, trifocal, lenticular single vision and multifocal lenses	Plan pays by lens type for two standard lenses: Single vision – up to $43, Bifocal – up to $58, Trifocal – up to $70, Lenticular: Single vision – $125 Multifocal – $125
Medically necessary contact lenses One pair or single lenses every 24 months in lieu of all other vision materials (Medically necessary contact lenses must be prior authorized)	Plan pays up to $250 *($125 per lens)*	Plan pays up to $250 *($125 per lens)*
Non-medically necessary contact lenses One pair every 24 months in lieu of all other vision materials	Plan allows up to $120 in lieu of all other vision materials	Plan pays up to $105 in lieu of all other vision materials

EXCLUSIONS AND LIMITATIONS

DENTAL

The following are selective listings only. For a comprehensive listing see the Health Net PPO Policy.

Limitations to covered services and supplies

1. Type I: Preventive and diagnostic dental services

Coverage is provided for the following preventive dental services and subject to the following limitations:

a) Initial or periodic oral exams, limited to one per six-month period. Initial exams will be limited to the allowance for a periodic exam.

b) Intraoral complete series X-rays, including 4 bitewings and up to 14 periapical X-rays, or panoramic film with 4 bitewings, either is limited to one per 36-month period and no payment for any combination of films shall exceed the amount determined for a complete series of X-rays.

c) Bitewing X-rays series (two or four films), limited to one per 12-month period.

d) If an intraoral complete or panoramic X-ray with bitewings has not been provided in a 36-month period, then a panoramic film without bitewings is a benefit and is limited to one per 36-month period.

e) Intraoral periapical X-rays, limited to four films per 6-month period when performed as a separate procedure from a complete series of X-rays.

f) Intraoral occlusal X-rays, limited to two films per 12-month period.

g) Extraoral X-rays, limited to two films per 12-month period.

h) Bitewing X-rays are not covered within a 12-month period from the date of an intraoral complete series X-rays.

i) Dental prophylaxis (cleaning and scaling), limited to one per 6-month period.

j) Topical fluoride treatment is limited to one per 12-month period for Dependent children under age 16.

k) Sealants are limited to one application to an unrestored permanent first or second molar tooth per 36-month period for Dependent children under age 14.

l) Space maintainers for primary teeth (limited to initial appliance only), including all adjustments and recementation made within 6 months of installation, limited to dependent children under age 14.

m) Emergency oral exams.

n) Limited oral evaluation, problem focused.

2. Type II: Basic dental services (non-restorative)

Coverage is provided for the following non-restorative basic dental services and subject to the following limitations:

a) Pulpotomy.

b) Root canal therapy, reimbursement includes preoperative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to one time on the same tooth.

c) Root canal retreatment, reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care performed not less than 12 months after the initial therapy, limited to one time on the same tooth per 12-month period.

d) Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), paid as a separate benefit only if services are performed not less than 12 months after the initial root canal therapy is completed. Reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

e) Periodontal scaling and root planing (per quadrant), limited to one time per quadrant per 24-month period and only if not performed on the same date of service as a prophylaxis or any other periodontal procedure.

f) For non-surgical periodontal procedures that are quadrant based and when there are less than 5 teeth remaining in the quadrant and the need for treatment is indicated, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.

g) For surgical periodontal procedures that are quadrant based and when there are less than 3 teeth requiring treatment, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.

h) Periodontal surgery related services as listed below, limited to:

- 1 time per quadrant of the mouth in any 36-month period with charges combined for gingivectomy, gingival curettage, or osseous surgery performed in the same quadrant within the same 36-month period.

i) Oral surgery services as listed below, including an allowance for local anesthesia and routine postoperative care:

- Simple extraction;
- Surgical extractions of erupted or impacted teeth;

- Alveoloplasty; and
- Excision of hyperplastic tissue – per arch.

j) General anesthesia and intravenous sedation is covered only in conjunction with the extraction of impacted teeth, limited as follows:

- Considered for payment as a separate benefit only when medically necessary as determined by Health Net Life.

k) Specialist consultation.

3. Type II: Basic Dental Services (Restorative)

Coverage is provided for the following restorative basic dental services and subject to the following limitations:

a) Amalgam restorations inclusive of any etching and bonding, limited as follows:

- Multiple restorations (surfaces) on a single tooth are combined for coverage purposes.
- Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 12 months have passed since the existing amalgam restoration was placed.
- Acid etch is not covered as a separate procedure.

b) Composite restorations inclusive of any etching and bonding, limited as follows:

- Multiple restorations (surfaces) on a single anterior tooth are combined for coverage purposes.
- Acid etch is not covered as a separate procedure.
- Benefits for the replacement of an existing anterior composite restoration will only be considered for payment if at least 12 months have passed since the existing anterior composite restoration was placed.
- Benefits for composite resin restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.

c) Stainless steel crowns are limited to one per tooth per 36-month period for members age 19 and under for teeth not restorable by an amalgam or composite filling.

4. Type III: Major dental services

Coverage is provided for the following major dental services and subject to the following limitations:

a) Inlays and onlays:

- Are covered only when the tooth cannot be restored by an amalgam filling.
- Are covered only if more than 5 years have elapsed since last placement; and
- Limited to persons age 19 and above.
- Composite or porcelain is not covered on molar teeth.

b) Porcelain substrate or metal crowns;

- Porcelain or porcelain fused to metal crowns are not covered on molar teeth.

c) Crowns:

- Are covered only when the tooth cannot be restored by an amalgam or composite filling.
- Are covered only if more than 5 years have elapsed since last placement; and
- Limited to persons over age 19.

d) Crown build-up, including pins and pre-fabricated posts. (Current periapical X-ray and narrative should indicate insufficient remaining tooth structure. Coverage is subject to determination of dental necessity.)

e) Post and core, covered only for endodontically treated teeth requiring crowns.

f) Full dentures, 1 time per arch, limited as follows:

- Replacement dentures are covered only if:
  1) 5 years have elapsed since last placement and the denture cannot be made serviceable; and
  2) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

g) Health Net Life will not pay additional benefits for personalized dentures or overdentures and associated treatment.

h) Partial dentures, including any clasps and rests and all teeth, 1 partial per arch, limited as follows:

- Replacement partial dentures are covered only if:
  1) 5 years have elapsed since last placement (please refer to the Denture or Bridge Replacement/Addition provision for exceptions) and the partial denture cannot be made serviceable; and
  2) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

i) There is no benefit for precision or semi-precision attachments.

j) Each additional clasp and rest.

k) Full or partial dentures, adjustments limited to one time per arch in any 12-month period following the initial 6-month denture placement period.

l) One repair per arch to full or partial dentures and bridges limited to repairs performed more than 12 months after the initial insertion; repairs are limited to those resulting from normal wear and to one repair every 12 months.

m) Relining or rebasing dentures, limited to:

- 1 time per arch per 36-month period; and
- For standard dentures, when done within 12 months or the insertion of the denture.
- For immediate dentures, when done within 6 months after the insertion of the denture.

n) Stayplates (temporary partial dentures) are limited to the replacement of anterior teeth and only during the healing phase following extractions.

o) Benefits for the replacement of an existing fixed partial denture are payable only if the existing bridge:

   1) Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision for exceptions);
   2) Cannot be made serviceable; and
   3) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

   - A fixed partial denture is the benefit for the replacement of a missing single tooth only if there are no other missing teeth in the same arch.
   - A removable partial denture is the benefit for the replacement of more than 1 missing tooth in the same arch, limited to one per 5 years.

5. Denture or bridge replacement/addition

Health Net Life will not pay for the replacement of a full denture, partial denture, fixed partial denture or for teeth added to a partial denture unless:

a) 5 years have elapsed since last replacement of the denture or bridge;

b) The denture or bridge cannot be made serviceable;

c) The denture or bridge was damaged while in the member's mouth when an injury was suffered while insured under the Policy, and it cannot be made serviceable; and

d) 2 years have elapsed after the member's effective date of coverage under the Dental Plan. However, the following exceptions will apply:

e) Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a dentally necessary extraction of an additional functioning natural tooth and the partial denture cannot be made serviceable.

f) For an existing fixed partial denture that is less than 5 years old, and an existing abutment or a functioning natural tooth within the same arch is extracted, the covered benefit will be a partial denture.

6. Missing teeth limitation

Health Net Life will not pay benefits for replacement of teeth missing on you or your dependents' effective date of coverage for the purpose of the initial placement of a full denture, partial denture or fixed partial denture (bridge), except as follows:

a) The initial placement of full or partial dentures will be considered a covered dental charge if the placement includes the initial replacement of a functioning natural tooth extracted while the member is insured under the Policy.

b) The initial placement of a fixed partial denture will be considered a covered dental charge if the placement includes the initial replacement of a functioning natural tooth extracted while the member is insured under the Policy. However, the following restrictions will apply:

   - Benefits will only be covered for the replacement of the teeth extracted while the member is covered under the Policy and the replacement is furnished within 12 months of the date the tooth was first extracted.
   - Benefits will not be covered for the replacement of other teeth that were missing on the member's effective date. Please refer to the Type III: Major Dental Services section of the Policy for further information.

General Exclusions

Health Net Life will not pay expenses incurred for any of the following:

1. Treatment that is: a) not included in the Dental Plan Schedule of Benefits; b) not dentally necessary; or c) Experimental in nature.
2. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
3. Services and supplies provided primarily for cosmetic purposes.
4. Crowns, inlays, cast restorations or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling.
5. Athletic mouthguards; denture duplication; infection control; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
6. Implants, related procedures or services involving root form implants.
7. Grafting (bone or tissue) and guided tissue regeneration.
8. Prescription drugs or any medications are not covered.
9. Services, procedures or supplies for which a charge would not have been made in the absence of insurance.
10. Procedures, services or supplies for which the member does not have to pay, except when payment of such benefits is required by law and then only to the extent required by law.
11. Treatment will be considered a covered service and supply only when the member is eligible for services on the date treatment is started. Payment is based on the start date.
12. Services and supplies obtained while outside the United States, except for emergency dental care.

VISION

The following is a selective listing only. For a comprehensive listing see the Health Net PPO policy.

1. Charges for procedures, services or materials that are not included as covered charges.
2. Any portion of a charge in excess of the maximum benefit allowance.
3. Expenses for any non-standard corrective lens materials, including but not limited to the following: coated, dyed, glass lens tints or laminated lenses, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromatic / photosensitive lenses.
4. Non-prescription lenses.
5. Orthoptics, vision training and low vision aids and any associated supplemental testing.
6. Medical or surgical treatment of the eye including, but not limited to, Laser In Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK).
7. Prescription or non-prescription medications.
8. Any eye examination or any corrective eyewear required as a condition of employment.
9. Services or materials which the company determines to be experimental, cosmetic or not medically necessary.
10. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
11. Services and materials furnished in conjunction with excluded services and materials.
12. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
13. Services and materials that a covered person received during a service interval under any other plan offered by the company or one of the company's affiliates.
14. Charges incurred before a covered person's effective date of coverage under the policy or after such coverage terminates.
15. Services or materials received as a result of disease, defect or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
16. Services and materials obtained while outside the United States, except for emergency vision care.
17. Services or materials resulting from or in the course of your or a dependent's regular occupation for pay or profit for which you or your dependent is entitled to benefits under any Worker's Compensation law, employer's liability law or similar law. You must promptly claim and notify the company of all such benefits.
18. As follows:
    - Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, Health Net Life will always reimburse any state or local medical assistance (Medicaid) agency for covered services and materials;
    - Charges not imposed against the person or for which the person is not liable;
    - Charges reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including part B) but did not do so, his or her benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under employers who notify the company that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively working employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.
19. Services, procedures or materials for which a charge would not have been made in the absence of insurance.

Prior authorization

Certain vision services require prior authorization by Health Net Life in order to be covered. This means that the vision provider must contact Health Net Life to request that the service be approved before it is provided. Requests for prior authorization will be denied if the requested service is not medically necessary.

For more information, please contact:

Health Net
Post Office Box 1150
Rancho Cordova, California 95741-1150

Individual & Family Plans:
1-800-909-3447

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device
for the Hearing and Speech Impaired:
1-800-995-0852

Visit www.healthnet.com
for the most up-to-date listings

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