Health Net of California, Inc. and
Health Net Life Insurance Company (Health Net)

SMALL BUSINESS GROUP

Ancillary Products Guide

YOUR GUIDE TO HEALTH NET PLANS FOR 1–100 EMPLOYEES

Effective January 1, 2020

BROKER COMMUNICATIONS

Coverage for every stage of life™

Ancillary Products

DENTAL, VISION, LIFE, AND AD&D

Designing a well-rounded benefits package is easy with Health Net. Complementing our collection of medical plans are the essentials that help employees reach their optimum health. Adding benefits such as dental and vision can help members lead a healthier lifestyle, so they can be more productive.

Table of Contents

Affordable Dental and Vision Plans for Complete Coverage 2

Complete Coverage in One Stop With Health Net 3

Dental Plans 4

Dental Plan Highlights 5

Dental Plan Portfolio 6

Vision Plans 13

Vision Plan Portfolio 14

Life and AD&D Plans 21

Exclusions and Limitations 22

Contact Us . . . . Back Cover

We look forward to helping you offer the **benefits** employees **value** at a cost that's good for business.

Pediatric dental and vision coverage (ages newborn through 18) are automatically included on all Health Net medical plans.

Affordable Dental and Vision Plans for Complete Coverage

Our members now enjoy one of the lowest cost options in the market when they combine Health Net medical coverage with our dental and vision plans. Pair those savings with robust networks of quality providers, and the choice to bundle is a no-brainer! But that's not all – a simple but diverse spread of options, relaxed underwriting guidelines, and our new one-page application form make it easy to add dental or vision to an existing medical plan!

Complete Coverage in One Stop with Health Net

Adding dental and vision coverage to your clients' existing medical plans helps them deliver comprehensive benefits to their employees. Health Net makes it simple to design a complete benefits package with a one-page dental/vision application form. Here are more great reasons to combine your clients' coverage:

- **NEW! Voluntary Dental/Vision with 2 underwriting program –** Sell more dental and vision with no DE 9C or payroll required for any group requesting voluntary dental/vision rates. Minimum enrollment of 2 employees per plan is needed.
- **Health Net members enjoy a competitive cost** when their employers combine medical, dental and vision.
- **Relaxed underwriting guidelines –** Only 50% of employees need to participate for employer–paid rates.[1]
- **Simple renewal process –** Add dental or vision coverage to an existing plan with our new streamlined renewal process.
- **Commission –** You receive a 10% broker commission on all dental and vision sales.

[1]Health Net offers employer-paid dental and vision rates, which require 50% participation. Voluntary rates also available under separate underwriting guidelines.

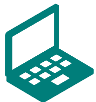
Health Net Dental Plans that Make Them Smile

Experienced, quality providers

Dental Benefit Providers (DBP) has partnered with Health Net for more than ten years to administer dental benefits. DBP recruits qualified providers throughout the region to ensure members have easy access to local specialists and general practice dentists.

Robust network

Through DBP, we offer more than 2,200 HMO dental office locations and 52,100 PPO dental providers in California, one of the largest networks in the state. This includes more than 14,000 PPO dental providers in Los Angeles County and more than 2,500 PPO dental providers in Sacramento County.



Easy online access

Members can view and print ID cards, view benefit details, view claims status, find a provider and more at **www.yourdentalplan.com/healthnet.**

Dental HMO plan highlights

- **Added cleanings and adult fluoride.**
- **Material upgrades, such as porcelain and semiprecious or precious metal molar crowns.**
- **General anesthesia, and cosmetic and elective dentistry – services typically not covered under most other carriers' dental plans.**
- **Implant coverage.**

Dental PPO plan highlights

- **No waiting periods on any of our DPPO Plans!**
- **Out-of-network reimbursement.**
- **Periodontics, endodontics and oral surgery are covered under General Services on the Classic and Essential plans.**
- **Support for healthy pregnancy with additional cleanings and periodontal maintenance for moms-to-be.**
- **Employees and dependents receive the full amount of the orthodontia lifetime maximum even if they have begun treatment under another carrier's dental PPO plan (applies only to DPPO plans with orthodontia coverage).**
- **Classic DPPO plans reimburse out-of-network benefits at usual, customary and reasonable (UCR) amounts.**
- **Essential DPPO plans reimburse out-of-network benefits on a limited fee schedule.**

Underwriting highlights

- **Dual option available – group may select 2 DPPO plans, 2 DHMO plans, or 1 DHMO and 1 DPPO plan. (Please see "Small Business Group Dental and Vision buy-up guidelines" to determine if the group qualifies for dual option.)**
- **Voluntary DPPO plans without orthodontia are available to groups with a minimum of 2 enrolled employees.**
- **Voluntary DPPO plans with orthodontia are available to groups of 10 or more enrolled employees.**

DHMO Plus 150

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DHMO Plus 150
Covered procedures (partial list)	Member copayment (in–network only)
Calendar year maximum that plan pays	Unlimited
Deductible	$0
Diagnostic D0120 Periodic oral evaluation	$0
D0150 Comprehensive oral evaluation	$0
D0210 Intraoral X-rays – complete series	$0
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	$20
D1206 Topical application of fluoride	$0
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	Not applicable
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	$0
D2331 Composite (white filling) – two surfaces anterior	$0
D2392 Composite (white filling) – two surfaces posterior	$30
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	$150
D2962 Labial veneer (porcelain laminate) – laboratory	$350
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	$95
D3330 Root canal – molar (ex. final restoration)	$125
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	$35
Prosthodontics D5110 Complete denture – upper	$175
Implants D6010 Surgical placement of implant body – endosteal implant	$1,950
Oral Surgery D7220 Removal of impacted tooth – soft tissue	$35
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	$1,695
Other general services D9972 External bleaching (teeth whitening) – per arch	$125

DHMO Plus 225

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DHMO Plus 150
Covered procedures (partial list)	Member copayment (in–network only)
Calendar year maximum that plan pays	Unlimited
Deductible	$0
Diagnostic D0120 Periodic oral evaluation	$0
D0150 Comprehensive oral evaluation	$0
D0210 Intraoral X-rays – complete series	$0
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	$35
D1206 Topical application of fluoride	$0
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	Not applicable
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	$0
D2331 Composite (white filling) – two surfaces anterior	$0
D2392 Composite (white filling) – two surfaces posterior	$45
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	$225
D2962 Labial veneer (porcelain laminate) – laboratory	$350
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	$125
D3330 Root canal – molar (ex. final restoration)	$210
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	$40
Prosthodontics D5110 Complete denture – upper	$260
Implants D6010 Surgical placement of implant body – endosteal implant	$1,950
Oral Surgery D7220 Removal of impacted tooth – soft tissue	$45
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	$1,695
Other general services D9972 External bleaching (teeth whitening) – per arch	$125

Health Net®

DPPO Classic 4 1500

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DPPO Classic 4 1500	
Covered procedures (partial list)	**Member pays (in-network)**	**Member pays (Out-of-Network)**
Calendar year maximum that plan pays	$1,500	
Deductible	$50 Single/ $150 Family	$75 single / $225 family
Diagnostic D0120 Periodic oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0150 Comprehensive oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0210 Intraoral X-rays – complete series	$0 (ded. waived)	$0 (ded. waived)
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0 (ded. waived)	$0 (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	$0 (ded. waived)	$0 (ded. waived)
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	$0 (ded. waived)	$0 (ded. waived)
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	20%, after ded.	20%, after ded.
D2331 Composite (white filling) – two surfaces anterior	20%, after ded	20%, after ded
D2392 Composite (white filling) – two surfaces posterior	20%, after ded.	20%, after ded.
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	50%, after ded.	50%, after ded.
D2962 Labial veneer (porcelain laminate) – laboratory	50%, after ded.	50%, after ded.
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	20%, after ded.	20%, after ded.
D3330 Root canal – molar (ex. final restoration)	20%, after ded.	20%, after ded.
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	20%, after ded.	20%, after ded.
Prosthodontics D5110 Complete denture – upper	50%, after ded.	50%, after ded.
Implants D6010 Surgical placement of implant body – endosteal implant	Not Covered	Not Covered
Oral Surgery D7220 Removal of impacted tooth – soft tissue	20%, after ded.	20%, after ded.
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	Not covered	Not covered
Other general services D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

Health Net®

DPPO Classic 5 1500

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DPPO Classic 5 1500	
Covered procedures (partial list)	**Member pays (in-network)**	**Member pays (Out-of-Network)**
Calendar year maximum that plan pays	$1,500	
Deductible	$50 Single/ $150 Family	$75 single / $225 family
Diagnostic D0120 Periodic oral evaluation	$0 (ded. waived)	20% (ded. waived)
D0150 Comprehensive oral evaluation	$0 (ded. waived)	20% (ded. waived)
D0210 Intraoral X-rays – complete series	$0 (ded. waived)	20% (ded. waived)
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0 (ded. waived)	20% (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	$0 (ded. waived)	20% (ded. waived)
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	$0 (ded. waived)	$0 (ded. waived)
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	20%, after ded.	20%, after ded.
D2331 Composite (white filling) – two surfaces anterior	20%, after ded	20%, after ded
D2392 Composite (white filling) – two surfaces posterior	20%, after ded.	20%, after ded.
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	50%, after ded.	50%, after ded.
D2962 Labial veneer (porcelain laminate) – laboratory	50%, after ded.	50%, after ded.
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	20%, after ded.	20%, after ded.
D3330 Root canal – molar (ex. final restoration)	20%, after ded.	20%, after ded.
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	20%, after ded.	20%, after ded.
Prosthodontics D5110 Complete denture – upper	50%, after ded.	50%, after ded.
Implants D6010 Surgical placement of implant body – endosteal implant	Not Covered	Not Covered
Oral Surgery D7220 Removal of impacted tooth – soft tissue	20%, after ded.	20%, after ded.
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	50%, after ded. $1,500 lifetime max.	50%, after ded. $1,500 lifetime max.
Other general services D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

DPPO Essential 2 1000

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DPPO Essential 2 1000	
Covered procedures (partial list)	**Member pays (in-network)**	**Member pays (Out-of-Network)**
Calendar year maximum that plan pays	$1,000	
Deductible	$50 Single/ $150 Family	$75 single / $225 family
Diagnostic D0120 Periodic oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0150 Comprehensive oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0210 Intraoral X-rays – complete series	$0 (ded. waived)	$0 (ded. waived)
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0 (ded. waived)	$0 (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	$0 (ded. waived)	$0 (ded. waived)
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	$0 (ded. waived)	$0 (ded. waived)
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	20%, after ded.	20%, after ded.
D2331 Composite (white filling) – two surfaces anterior	20%, after ded	20%, after ded
D2392 Composite (white filling) – two surfaces posterior	20%, after ded.	20%, after ded.
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	50%, after ded.	50%, after ded.
D2962 Labial veneer (porcelain laminate) – laboratory	50%, after ded.	50%, after ded.
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	20%, after ded.	20%, after ded.
D3330 Root canal – molar (ex. final restoration)	20%, after ded.	20%, after ded.
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	20%, after ded.	20%, after ded.
Prosthodontics D5110 Complete denture – upper	50%, after ded.	50%, after ded.
Implants D6010 Surgical placement of implant body – endosteal implant	Not Covered	Not Covered
Oral Surgery D7220 Removal of impacted tooth – soft tissue	20%, after ded.	20%, after ded.
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	Not covered	Not covered
Other general services D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

DPPO Essential 5 1500

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DPPO Essential 5 1500	
Covered procedures (partial list)	**Member pays (in-network)**	**Member pays (Out-of-Network)**
Calendar year maximum that plan pays	$1,500	
Deductible	$50 Single/ $150 Family	$75 single / $225 family
Diagnostic D0120 Periodic oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0150 Comprehensive oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0210 Intraoral X-rays – complete series	$0 (ded. waived)	$0 (ded. waived)
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0 (ded. waived)	$0 (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	$0 (ded. waived)	$0 (ded. waived)
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	$0 (ded. waived)	$0 (ded. waived)
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	20%, after ded.	20%, after ded.
D2331 Composite (white filling) – two surfaces anterior	20%, after ded	20%, after ded
D2392 Composite (white filling) – two surfaces posterior	20%, after ded.	20%, after ded.
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	50%, after ded.	50%, after ded.
D2962 Labial veneer (porcelain laminate) – laboratory	50%, after ded.	50%, after ded.
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	20%, after ded.	20%, after ded.
D3330 Root canal – molar (ex. final restoration)	20%, after ded.	20%, after ded.
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	20%, after ded.	20%, after ded.
Prosthodontics D5110 Complete denture – upper	50%, after ded.	50%, after ded.
Implants D6010 Surgical placement of implant body – endosteal implant	Not Covered	Not Covered
Oral Surgery D7220 Removal of impacted tooth – soft tissue	20%, after ded.	20%, after ded.
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	50%, after ded. $1,500 lifetime max.	50%, after ded. $1,500 lifetime max.
Other general services D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

DPPO Essential 6 1500

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	DPPO Essential 2 1000	
Covered procedures (partial list)	**Member pays (in-network)**	**Member pays (Out-of-Network)**
Calendar year maximum that plan pays	$1,500	
Deductible	$50 Single/ $150 Family	$75 single / $225 family
Diagnostic D0120 Periodic oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0150 Comprehensive oral evaluation	$0 (ded. waived)	$0 (ded. waived)
D0210 Intraoral X-rays – complete series	$0 (ded. waived)	$0 (ded. waived)
Preventive D1110 Prophylaxis (2 cleanings per year) – adult	$0 (ded. waived)	$0 (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	$0 (ded. waived)	$0 (ded. waived)
Prenantal Dental care If medically necessary, women in their second and third trimesters are eligible to receive additional prophylaxis, deep cleaning, debridement, and periodontal maintenance (covered expenses do not apply to the calendar year maximum)	$0 (ded. waived)	$0 (ded. waived)
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	20%, after ded.	20%, after ded.
D2331 Composite (white filling) – two surfaces anterior	20%, after ded	20%, after ded
D2392 Composite (white filling) – two surfaces posterior	20%, after ded.	20%, after ded.
Crowns and pontics D2751 Crown – porcelain fused to predominantly base metal	50%, after ded.	50%, after ded.
D2962 Labial veneer (porcelain laminate) – laboratory	50%, after ded.	50%, after ded.
Endodontics D3320 Root canal – bicuspid (ex. final restoration)	20%, after ded.	20%, after ded.
D3330 Root canal – molar (ex. final restoration)	20%, after ded.	20%, after ded.
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	20%, after ded.	20%, after ded.
Prosthodontics D5110 Complete denture – upper	50%, after ded.	50%, after ded.
Implants D6010 Surgical placement of implant body – endosteal implant	Not Covered	Not Covered
Oral Surgery D7220 Removal of impacted tooth – soft tissue	20%, after ded.	20%, after ded.
Orthodontics D8070-90 Comprehensive orthodontic treatment – adult or child	Not covered	Not covered
Other general services D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

Health Net Vision Plans Have Clear Advantages

Health Net partners with EyeMed to deliver vision services. With more than 30 years of experience and 55 million members, EyeMed is America's fastest-growing vision benefits company. EyeMed's network features a mix of independent and retail providers, including both national and regional favorites like LensCrafters, so members can go where they want, when they want.

Convenient network

EyeMed offers in-network access to more than 111,000 optometrists, ophthalmologists and licensed opticians at more than 28,500 locations throughout the country. Online options let members purchase eyewear and contacts with a PC, tablet or phone. Plus, members can see any provider they choose, either in-network or out-of-network.

Cost savings

Delivering extra value with low-copayment plan choices, and 5–15% discount on LASIK and PRK from U.S. Laser Network.

Member tools

EyeMed's hassle-free member tools save time and provide peace of mind. Members get access to an enhanced provider search tool, a mobile app, online appointment scheduling, and an award-winning 24-7 Customer Care Center.

Easy online access

Members can view and print ID cards, review benefits, manage claims, find a provider, calculate costs and more at **www.eyemedvisioncare.com.**

New vision plans for 2020 include:

- Elite 1010-1
- Supreme 010-2
- Plus 20-1
- Exam only

Vision Plans

Elite 1010-1

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Elite 1010-1	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$10 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Up to $55 Copay	No Discount
Premium contact lenses	10% Discount	No Discount
Frames Any available frame at provider location	$150 allowance, plus 20% off balance over allowance	Up to $45
Standard Plastic Lenses Single Vision	$10 Copay	Up to $40
Bifocal	$10 Copay	Up to $60
Trifocal	$10 Copay	Up to $80
Lenticular	$10 Copay	Up to $80
Standard Progressive Lens	$75 Copay	Up to $60
Premium Progressive Lens	$75 copay, then 80% of total charges less $120 allowance	Up to $60
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	$120 allowance	No Discount
Conventional	$0 Copay, plus 15% discount off balance over allowance	Up to $105
Disposable	$0 Copay, plus balance over allowance	Up to $105
Medically Necessary	Paid in Full	Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 12 months	

Supreme 010-2

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Supreme 010-2	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$0 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Up to $55 Copay	No Discount
Premium contact lenses	10% Discount	No Discount
Frames Any available frame at provider location	$120 allowance, plus 20% off balance over allowance	Up to $45
Standard Plastic Lenses Single Vision	$10 Copay	Up to $40
Bifocal	$10 Copay	Up to $60
Trifocal	$10 Copay	Up to $80
Lenticular	$10 Copay	Up to $80
Standard Progressive Lens	$75 Copay	Up to $60
Premium Progressive Lens	$75 copay, then 80% of total charges less $120 allowance	Up to $60
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	$105 allowance	No Discount
Conventional	$0 Copay, plus 15% discount off balance over allowance	Up to $105
Disposable	$0 Copay, plus balance over allowance	Up to $105
Medically Necessary	Paid in Full	Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

Preferred 1025-2

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Preferred 1025-2	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$10 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Up to $55 Copay	No Discount
Premium contact lenses	10% Discount	No Discount
Frames Any available frame at provider location	$100 allowance, plus 20% off balance over allowance	Up to $45
Standard Plastic Lenses Single Vision	$25 Copay	Up to $40
Bifocal	$25 Copay	Up to $60
Trifocal	$25 Copay	Up to $80
Lenticular	$25 Copay	Up to $80
Standard Progressive Lens	$90 Copay	Up to $60
Premium Progressive Lens	$90 copay, then 20% of total charges less $120 allowance	Up to $60
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	$90 allowance	No Discount
Conventional	$0 Copay, plus 15% discount off balance over allowance	Up to $105
Disposable	$0 Copay, plus balance over allowance	Up to $105
Medically Necessary	Paid in Full	Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

Preferred 1025-3

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Preferred 1025-3	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$10 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Up to $55 Copay	No Discount
Premium contact lenses	10% Discount	No Discount
Frames Any available frame at provider location	$100 allowance, plus 20% off balance over allowance	Up to $45
Standard Plastic Lenses Single Vision	$25 Copay	Up to $40
Bifocal	$25 Copay	Up to $60
Trifocal	$25 Copay	Up to $80
Lenticular	$25 Copay	Up to $80
Standard Progressive Lens	$90 Copay	Up to $60
Premium Progressive Lens	$90 copay, then 80% of total charges less $120 allowance	Up to $60
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	$90 allowance	No Discount
Conventional	$0 Copay, plus 15% discount off balance over allowance	Up to $105
Disposable	$0 Copay, plus balance over allowance	Up to $105
Medically Necessary	Paid in Full	Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 12 months	
Lenses or contact lenses	Once every 24 months	
Frame	Once every 24 months	

Health Net®

Preferred Value 10-3

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Preferred Value 10-3	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	Not Covered	Not Covered
Exam Options (fit and follow up) Standard contact lenses	Not Covered	Not Covered
Premium contact lenses	Not Covered	Not Covered
Frames Any available frame at provider location	$100 allowance, plus 20% off balance over allowance	Up to $45
Standard Plastic Lenses Single Vision	$10 Copay	Up to $40
Bifocal	$10 Copay	Up to $60
Trifocal	$10 Copay	Up to $80
Lenticular	$10 Copay	Up to $80
Standard Progressive Lens	$75 Copay	Up to $60
Premium Progressive Lens	$75 copay, then 80% of total charges less $120 allowance	Up to $60
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	$90 allowance	No Discount
Conventional	$0 Copay, plus 15% discount off balance over allowance	Up to $105
Disposable	$0 Copay, plus balance over allowance	Up to $105
Medically Necessary	Paid in Full	Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Not Covered	
Lenses or contact lenses	Once every 24 months	
Frame	Once every 24 months	

Plus 20-1

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Plus 20-1	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$20 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Not Covered	Not Covered
Premium contact lenses	Not Covered	Not Covered
Frames Any available frame at provider location	35% discount off retail price	No Discount
Standard Plastic Lenses Single Vision	$50 Copay	No Discount
Bifocal	$70 Copay	No Discount
Trifocal	$105 Copay	No Discount
Lenticular	Not Covered	Not Covered
Standard Progressive Lens	$135 Copay	No Discount
Premium Progressive Lens	Not Covered	Not Covered
Lens Options UV Treatment	$15 Copay	No Discount
Tint (Solid and Gradient)	$15 Copay	No Discount
Standard Plastic Scratch Coating	$15 Copay	No Discount
Standard Polycarbonate	$40 Copay	No Discount
Standard Anti-Reflective Coating	$45 Copay	No Discount
Other Add-Ons	20% Discount	No Discount
Contact Lenses (includes materials only)	Not Covered	Not Covered
Conventional	Not Covered	Not Covered
Disposable	Not Covered	Not Covered
Medically Necessary	Not Covered	Not Covered
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 12 months	
Lenses or contact lenses	Unlimited	
Frame	Unlimited	

Exam Only

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefits	Exam Only	
	Par Provider	**Any Other Provider Reimbursement**
Exam Exam with dilation as necessary	$0 Copay	Up to $40
Exam Options (fit and follow up) Standard contact lenses	Not Covered	Not Covered
Premium contact lenses	Not Covered	Not Covered
Frames Any available frame at provider location	Not Covered	Not Covered
Standard Plastic Lenses Single Vision	Not Covered	Not Covered
Bifocal	Not Covered	Not Covered
Trifocal	Not Covered	Not Covered
Lenticular	Not Covered	Not Covered
Standard Progressive Lens	Not Covered	Not Covered
Premium Progressive Lens	Not Covered	Not Covered
Lens Options UV Treatment	Not Covered	Not Covered
Tint (Solid and Gradient)	Not Covered	Not Covered
Standard Plastic Scratch Coating	Not Covered	Not Covered
Standard Polycarbonate	Not Covered	Not Covered
Standard Anti-Reflective Coating	Not Covered	Not Covered
Other Add-Ons	Not Covered	Not Covered
Contact Lenses (includes materials only)	Not Covered	Not Covered
Conventional	Not Covered	Not Covered
Disposable	Not Covered	Not Covered
Medically Necessary	Not Covered	Not Covered
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No Discount
Secondary purchase plan Discounts on eyewear purchases after initial benefits utilized	Scheduled benefits up to 40% off retail	No Discount
Frequency Exam	Once every 24 months	
Lenses or contact lenses	Not Covered	
Frame	Not Covered	

Life and Accidental Death & Dismemberment

For many small businesses, an attractive employee benefits package includes Group Term Life and Accidental Death & Dismemberment (AD&D) insurance offering desirable benefit levels. This allows a small business employer to:

- Increase the attractiveness of the company's benefit package to employees.
- Offer employees life insurance benefits at economical rates.

One way employers can enhance their benefits package and minimize administrative costs is to consolidate health and life insurance carriers. Carrier consolidation eliminates unnecessary administrative costs related to managing an employee benefits package.

GROUP LIFE PLAN FEATURES

- **Waiver of premium provision –** A life benefit can be extended during a period of total disability under terms specified in the group *Certificate of Insurance*.
- **Accelerated death benefit –** Provides financial protection to the insured in time of need, while also protecting the interest of the beneficiary. The accelerated benefit is a portion of the basic life insurance amount and is payable in a lump sum.
- **Conversion privilege –** A conversion privilege to whole life insurance is available to certain individuals whose coverage terminates due to reasons specified in the group policy.

AD&D

These benefits are usually included as part of the group life insurance policy. Health Net Life Insurance Company does not offer Accidental Death & Dismemberment benefits on a standalone basis.

- Benefit is payable as a result of an accidental loss of life or any of the physical losses specified in the group policy.
- The maximum benefit amount is equal to the basic life amount shown in the policy.
- This maximum benefit amount is payable for loss of life. It can also be payable for the loss of sight in both eyes, loss of both hands or both feet, or any two or more of these physical losses in the same accident.
- One-half of the maximum benefit amount is payable for loss of one hand, loss of one foot or the loss of sight in one eye.

Group Term Life Insurance

LIFE OPTIONS

Option A – **$15,000 flat amount for all employees**

Option B – **$25,000 flat amount for all employees (15–100 employees)**

Option C – **$50,000 flat amount for all employees (25–100 employees)**

Exclusions and Limitations

Dental HMO

GENERAL EXCLUSIONS

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

Orthodontic exclusions and limitations

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

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

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

LIMITATIONS

General

General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine cleanings (prophylaxis), periodontal maintenance services and fluoride treatments are limited to twice a year.

   Two (2) additional cleanings (routine and periodontal) are available at the copayment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

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

Restorative

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

Prosthodontics

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

Endodontics

The copayments listed for endodontic procedures do not include the cost of the final restoration.

Oral surgery

The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.

Implants (DHMO Plus plans only)

1. Replacement of implants, implant crowns, implant prosthesis, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.
2. Implant placement. Limited to 1 time per consecutive 60 months.
3. Implant supported prosthetics. Limited to 1 time per consecutive 60 months.
4. Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis. Limited to 1 time per consecutive 12 months.
5. Repair implant supported prosthesis, by report. Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.
6. Abutment supported crown (titanium) or retainer crown for FPD – titanium. Limited to 1 time per consecutive 60 months.
7. Repair implant abutment, by report. Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.
8. Implant removal, by report. Limited to 1 time per consecutive 60 months.
9. Radiographic/surgical implant index, by report. Limited to 1 time per consecutive 60 months.

Classic and Essential Plans

GENERAL EXCLUSIONS

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

LIMITATIONS

1. Dental services are covered at the least costly, clinically accepted treatment. (Posterior composites and gold foil restorations are automatically alt benefited to amalgam fillings; high noble crowns and pontics are automatically alt benefited to noble crowns and pontics.)
2. Oral evaluations (ADA codes D0120–D0180) are covered as a separate benefit only if no other service was done during the visit other than prophy and X–rays. Limited to 2 times per 12 consecutive months.
3. Intraoral–complete series, vertical bitewings and panorex radiographs (ADA codes D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Exception to the 36-month limit on panorex radiographs will be made if taken for diagnosis of third molars, cysts or neoplasms. Vertical bitewings can not be billed in conjunction with a complete series.
4. Extraoral radiographs (ADA codes D0250 and D0251) are limited to 2 films per plan year.
5. Bitewing radiographs (ADA codes D0270, D0272, D0273 and D0274) are limited to 1 series of films per plan year.
6. Oral cancer screening (Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytoloty or biopsy procedures) (ADA code D0431) is limited to 1 time per consecutive 12 months.

7. Dental prophylaxis (ADA codes D1110 and D1120) is limited to 2 times per 12 consecutive months.
8. Diagnostic casts (ADA code D0470) limited to 1 time per consecutive 24 months.
9. Fluoride treatment (ADA codes D1208 and D1206) limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.
10. Sealants (ADA code D1351) limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
11. Space maintainers (ADA codes D1510, D1515, D1516, D1517, D1520, D1525, D1526, and D1527) are limited to covered persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
12. Re-cement space maintainers (ADA code D1550) is limited to 1 per consecutive 6 months after initial insertion.
13. Multiple restorations on one surface (ADA codes D2140, D2330 and D2391) will be treated as a single filling.
14. Pin retention (ADA code D2951) limited to 2 pins per tooth; not covered in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.)
15. Inlays (ADA codes D2510–D2530, D2610–D2630, D2650–D2652) and onlays (ADA codes D2542–D2544, D2642–D2644, D2662 –D2664) are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
16. Re–cement inlays/onlays, crowns, bridges and post and core. Limited to those performed more than 12 months after the initial insertion.
17. Crowns (ADA codes D2390, D2710–D2792, D2794, D2799, D2930–D2934, D6205, and D6794) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth.
18. Prefabricated esthetic coated stainless steel crown (ADA code D2934) is limited to primary anterior teeth and has a frequency limit of 1 per consecutive 60 months (tooth range C–H and M–R).
19. Posts and cores (ADA codes D2952–D2954, and D2957) are covered only for teeth that have had root canal therapy.
20. Sedative fillings (ADA code D2940) are covered as a separate benefit only if no other service other than X-rays and exam were done on the same tooth during the visit.
21. Therapeutic pulpotomy (ADA code D3220) and pulpal therapy (resorbable filling) (ADA codes D3230 and D3240) are limited to 1 time per tooth per lifetime.
22. Pulpal debridement (ADA code D3221) is limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
23. Root canal therapy (ADA codes D3310–D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.
24. Apicoectomy and retrograde filling (ADA codes D3410, D3421, D3425, D3426 and D3430), root resection/amputation (ADA code D3450) and apexification (ADA codes D3351, D3352 and D3353) are limited to 1 time per tooth per lifetime.
25. Hemisection (ADA code D3920) is limited to 1 time per tooth per lifetime.
26. Scaling and root planing (ADA codes D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
27. Localized delivery of antimicrobial agents (ADA code D4381) is limited to 3 per quadrant or 12 sites total for refractory pockets or in conjunction with periodontal scaling and root planing (ADA codes D4341 and D4342).
28. Periodontal maintenance (ADA code D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (ADA code D4355).
29. Complete dentures (ADA codes D5110 and D5120), immediate dentures (ADA codes D5130 and D5140), interim complete dentures (ADA codes D5810 and D5811) and overdenture–complete by report (ADA code D5863–D5866) are limited to 1 per consecutive 60 months.
30. Partial dentures (ADA codes D5211–D5226), interim partial dentures (ADA codes D5820 and D5821), fixed partial denture pontics (ADA codes D6210–D6253), fixed partial denture retainers–inlays/onlays (ADA codes D6545–D6634) and fixed partial denture retainer–crowns (ADA codes D6710–D6793) are limited to 1 per consecutive 60 months. There are no additional allowances for precision or semiprecision attachments (ADA codes D5862, D5867 and D6950).
31. Relining and rebasing dentures (ADA codes D5710–D5761) is limited to relining/rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.
32. Repairs and adjustments to full dentures (ADA codes D5410, D5411, D5511 and D5520) or partial fixed or removable dentures (ADA codes D5421, D5422, D5611–D5612, D5621–D5671, D6930 and D6980) are limited to those done more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
33. Tissue conditioning – maxillary or mandibular (ADA codes D5850 and D5851) is limited to 1 per consecutive 12 months.
34. Oroantral fistula closure (ADA code D7260) is limited to 1 per site per visit.
35. Tooth reimplantation and/or transplantation services (ADA codes D7270 and D7272) is limited to 1 per site per lifetime.
36. Biopsy (ADA codes D7285–D7288) is limited to 1 biopsy per site per visit.
37. Vestibuloplasty (ADA codes D7340 and D7350) is limited to 1 time per site per consecutive 60 months.
38. Surgical incision (ADA codes D7510–D7521) is limited to 1 time per site per visit.
39. Palliative treatment (ADA code D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.
40. Occlusal guards (ADA code D9944–D9946) are covered only if prescribed to control habitual grinding and are limited to 1 guard per consecutive 36 months. Occlusal analysis – mounted case (ADA code D9950) is limited to 1 per consecutive 60 months.
41. Occlusal guard reline and repair (ADA code D9942) MUST be performed more than 6 months after initial insertion and is limited to 1 time per consecutive 12 months.
42. Full mouth debridement (ADA code 4355) is limited to 1 time per consecutive 36 months.
43. General anesthesia (ADA codes D9222–D9223, D9230, D9239, D9243 and D9248) is covered only when clinically necessary.
44. Osseous grafts (ADA codes D4260, D4261, D4265–D4267), with or without resorbable or non-resorbable GTR membrane placement (ADA codes D4245 and D4263–D4264), are limited to once every consecutive 36 months per quadrant or surgical site. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area are limited to once every 36 consecutive months. This includes gingivectomy or gingivoplasty (ADA codes D4210–D4212), gingival flap procedure (ADA codes D4240–D4241, D4245), osseous surgery (ADA codes D4260–D4261), pedicle grafts and free soft tissue grafts (ADA codes D4270, D4273, and D4275–D4276), crown lengthening hard tissue (ADA code D4249), anatomical crown exposure (ADA codes D4230 and D4231), clinical crown lengthening (ADA code D4249), bone replacement graph (ADA code D4264), surgical revision procedure, per tooth (ADA code 4268), distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) (ADA code D4274), and provisional splinting (ADA codes D4320 and D4321).
45. Replacement of complete or partial dentures (fixed and removable) (ADA codes D5110–D5226, D5282–D5283, D6210–D6254, D6545–D6793), and crowns (ADA codes D2710–D2794), previously submitted for payment under the plan is limited to once every 60 consecutive months from initial or supplemental placement.
46. Removal of a benign cyst/lesion (ADA codes D7410–D7412, D7450–D7461) is limited to 1 per site per visit.
47. Surgical access, surgical exposure or immobilization of unerupted teeth (ADA code D7280–D7281) is limited to 1 per site per lifetime.
48. Primary closure of a sinus perforation (ADA code D7261), placement of device to facilitate eruption of impacted tooth (ADA code D7283) and transseptal fiberotomy/supracrestal fiberotomy, by report (ADA code D7291) are limited to 1 per tooth per lifetime.
49. Bone replacement graft for ridge preservation – per site (ADA code D7953) is limited to 1 per site per lifetime and is not covered if done in conjunction with other bone graft replacement procedures.

50. Excision of hyperplastic tissue or pericoronal gingivia (ADA codes D7970 and D7971) is limited to 1 per site per consecutive 36 months.
51. Appliance removal (not by the dentist who placed the appliance; includes removal of arch bar) (ADA code 7997) is limited to once per appliance per lifetime.
52. Coping (ADA code D2975) is limited to 1 per tooth per consecutive 60 months and is not covered if done at the same time as a crown on the same tooth.
53. Therapeutic drug injection, by report/other drugs and/or medicaments, by report (ADA codes D9610–D9630) are limited to 1 per site per visit.
54. Any required copayment, deductible waiting period or maximum benefit is waived for a covered person in their 2nd or 3rd trimester of pregnancy of the following covered dental services: prophylaxis, scaling and root planing, periodontal maintenance and full–mouth debridement.
55. Local anesthesia. Not covered in conjunction with operative or surgical procedure.
56. Consultation. Not covered if done with exams or professional visits.

Vision – Preferred plans 1025-2 and 1025-3

GENERAL EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Any corrective eyewear, required by an employer as a condition of employment and safety eyewear, unless specifically covered under the policy.
4. Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.
5. Plano (nonprescription) lenses.
6. Nonprescription sunglasses.
7. Two pair of glasses in lieu of bifocals.
8. Services or materials provided by any other group benefit plans providing vision care.
9. Certain frame brands in which the manufacturer imposes a no–discount policy.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period when vision materials would next become available.

LIMITATIONS

Vision examination and vision materials – Fees charged by a provider for services other than vision examination or covered vision materials must be paid in full by the covered person to the provider. Such fees or materials are not covered under this policy. Benefit allowances provide no remaining balance for future use within the same benefit period.

Vision – Preferred Value Plan 10-3

GENERAL EXCLUSIONS

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Any vision examination.
4. Any eye, or vision examination, or any corrective eyewear, required by an employer as a condition of employment and safety eyewear, unless specifically covered under the policy.
5. Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.
6. Plano (nonprescription) lenses.
7. Nonprescription sunglasses.
8. Two pair of glasses in lieu of bifocals.
9. Services or materials provided by any other group benefit plans providing vision care.
10. Certain frame brands in which the manufacturer imposes a no–discount policy.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period when vision materials would next become available.

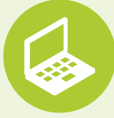
LIMITATIONS

Vision materials – Fees charged by a provider for services other than covered vision materials must be paid in full by the covered person to the provider. Such fees or materials are not covered under this policy. Benefit allowances provide no remaining balance for future use within the same benefit period.

Simplified. Sustainable. Small business–focused.

QUESTIONS? WE'RE HERE WITH ANSWERS.

Call your Health Net account manager.



Visit us online at www.healthnet.com/employer.

Read the latest news about Health Net at www.healthnetpulse.com.

For more information, please contact:

HEALTH NET
PO Box 9103
Van Nuys, CA 91409–9103

SMALL BUSINESS GROUP
SALES AND SERVICE ADMINISTRATION
1–800–447–8812 *(English)*
1–877–891–9050 *(Cantonese)*
1–877–339–8596 *(Korean)*
1–877–891–9053 *(Mandarin)*
1–800–331–1777 *(Spanish)*
1–877–891–9051 *(Tagalog)*
1–877–339–8621 *(Vietnamese)*

ASSISTANCE FOR THE HEARING AND SPEECH IMPAIRED
TTY: 711

www.healthnet.com

Health Net Dental HMO plans are provided by Dental Benefit Providers of California, Inc. ("DBP"). Health Net Dental PPO and indemnity plans are underwritten by Unimerica Life Insurance Company. Health Net Vision plans are underwritten by Health Net Life Insurance Company and serviced by Envolve Vision, Inc. and EyeMed Vision Care, LLC. Obligations of DBP, and Unimerica Life Insurance Company are not obligations of, or guaranteed by, Health Net, LLC or its affiliates. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC. Health Net is a registered service mark of Health Net, LLC. All rights reserved.

BKT036430EL00 (12/19)