Health Net of California, Inc. (Health Net)

University of California
Postdoctoral Scholar Benefit Program

Custom HN Value DHMO Plus 115[1]

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

Covered procedures (partial list)	Member responsibility (in-network only)
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
D1208 Topical application of fluoride, excluding fluoride varnish	$0
Prenatal 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
Restorative treatment D2150 Amalgam (silver filling) – two surfaces	$0
D2331 Composite (white filling) – two surfaces anterior	$0
D2392 Composite (white filling) – two surfaces posterior	$20
Crowns and pontics D2751 Crown[2] – porcelain fused to predominantly base metal	$115
D2962 Labial veneer (porcelain laminate)	$450
Endodontics D3320 Root canal – bicuspid (final restoration)	$80
D3330 Root canal – molar (final restoration)	$150
Periodontics D4341 Periodintal scaling and root planing – 4 or more teeth per quadrant	$25
Prosthodontics D5110 Complete denture – upper	$125
Oral Surgery D7220 Removal of impacted tooth – soft tissue	$35
Orthodontics D8080 Comprehensive orthodontic treatment – of the adolescent dentition	$1,950
D8090 Comprehensive orthodontic treatment – of the adult dentition	$2,250
Other general services D9972 External bleaching (teeth whitening) – per arch	$125

[1]Health Net Dental HMO plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). Obligations of DBP are not the obligations of, nor guaranteed by, Health Net, Inc. or its affiliates.

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

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.

Limitations

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating Health Net selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.

Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating Health Net selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.

2. 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, however it is available at 75% of your Health Net selected general or specialty care dentist's usual and customary fees.

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.

4. The retention phase of treatment shall include the construction, placement and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.