# SUMMARY OF BENEFITS

Plus PPO Dental Benefit Plan D5075-196-1000-S
Plan Code 3D
Underwritten by Unimerica Insurance Company

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Plan Coverage (In Network)*</th>
<th>Plan Coverage (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$50 per person</td>
<td>$75 per person</td>
</tr>
<tr>
<td></td>
<td>$150 per family</td>
<td>$225 per family</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial/routine oral exam, teeth cleaning &amp; routine scaling, fluoride treatment, sealant (children under 16), x-rays as part of a general exam, emergency exam, space maintainers</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No deductible</td>
<td>No deductible</td>
</tr>
<tr>
<td>General Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings, general anesthetics, oral surgery, periodontics, endodontics</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns, removable &amp; fixed bridges, complete &amp; partial dentures</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered under this plan</td>
<td></td>
</tr>
</tbody>
</table>

*Plan enrollees have access to contracted dentists who have agreed to accept our fee schedule as payment in full for covered procedures.

**Network Access:** You save when using a contracted dentist. Contracted dentists have agreed to reduce their treatment fees. Using a contracted dentist lowers your out-of-pocket expenses.

**Your Costs:** Payment from the Plan is based on the "usual & customary" charge that is preset for each procedure. This charge is determined by the complexity of the treatment and the fee most commonly charged for that procedure in a particular geographic area. This is the "maximum allowable" for any procedure and the benefit will be calculated based on the dentist’s submitted fee or the usual & customary amount - whichever is lower.

**Balance Billing:** If your dentist charges more than the usual & customary amount for a procedure, you are responsible for the difference between what is charged and the usual & customary amount. This is called "Balance Billing". If you receive treatment from a contracted dentist, you will not be "Balance Billed". Our contracted dentists have agreed to accept the preset usual & customary fees, plus your co-insurance payment, if any as payment in full.

**Limitations:**
- Initial/Routine Oral Exam: 2 per consecutive 12 months
- Teeth Cleaning: 2 per consecutive 12 months
- Fluoride Treatment: 2 per consecutive 12 months, children 16 years and under
- Seals: 1 per 36 months, children 16 years and under on permanent molars only
- Emergency Treatment: For relief of pain only

Additional Exclusions and Limitations are listed on the following page.

Health Net Dental PPO and Indemnity plans are underwritten by Unimerica Insurance Company. Obligations of Unimerica Insurance Company are not the obligations of or guaranteed by Health Net, Inc. or its affiliates.

*This is a summary of the benefits available under your plan. For a full list of benefits, limitations, and exclusions, please consult your Certificate of Coverage. In the event of a conflict between the terms of the Certificate of Coverage and this summary, the Certificate of Coverage will control.*
GENERAL LIMITATIONS

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANORAX RADIOPHOTHS Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorax Radiographs if taken for diagnosis of third molar, cysts or neoplasms.

BITING RADIOPHOTHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOPHOTHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

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

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

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

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

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

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

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

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-ray and exam, were performed on the same teeth during the visit.

SCALEING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

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

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

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

RELINING AND REBASED DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same teeth during the visit.

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

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only where clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

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

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes experimental 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 pharmaceutical regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by 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.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal association as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction.

17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crowns 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.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. 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.
22. Setting of facial bone fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. 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.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
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. 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.