



Health Net®

Health Net Health Plan of Oregon, Inc. Dental Net Benefit Schedule Health Net Plus D50-1855-1500/09

Access: With this Health Net of Oregon Dental Plan, you can see any licensed dentist and receive Benefits for covered services. You do not have to go to a specific network of Providers. However, if you do see a Participating Provider, charges for covered services will be limited to Health Net’s contracted amount with the Provider.

Service: We’re here to help you know what services are covered and how much your plan pays. Whenever you have questions, call us. We’re ready to help you make your Benefits work for you.

Deductible

The deductible is the amount you pay before your plan begins paying Benefits for covered services. The deductible does not apply to Part A services.

Deductible per Member	\$50 per Calendar Year
Maximum family deductible	\$150 per Calendar Year

Maximum Benefit

All non-orthodontic services combined	\$1,500 per Member per Calendar Year
All orthodontic services combined	\$1,500 per Member per lifetime

Waiting Periods for timely enrollees

Part A Services:	None
Part B Services:	None
Part C Services:	6 months

Waiting Periods for late enrollees

Part A Services:	None
Part B Services:	12 months
Part C Services:	12 months

Covered Services	Plan Pays:*	Benefit Limitations
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Part A Services: Diagnostic and Preventive Services

Periodic Oral Examinations	100%	2 times per consecutive 12 months
Dental Prophylaxis (cleaning)	100%	2 times per consecutive 12 months
Bitewing X-Rays	100%	1 series of films per Calendar Year
Full Mouth or Panoramic X-Rays	100%	1 time per consecutive 36 months
Extraoral X-Rays	100%	2 films per Calendar Year
Fluoride Treatments	100%	Under age 16, 2 times per Calendar Year
Sealants	100%	Under age 16, once per first or second permanent molar every 5 years

Covered Services	Plan Pays:*	Benefit Limitations
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Part B Services: Basic Services

Space Maintainers	80%	Under age 16, once per lifetime
Amalgam Restorations (fillings)	80%	1 restoration per surface every 3 years
Composite Resin Restorations (fillings)	80%	1 restoration per surface every 3 years
Sedative Filling	80%	Covered as a separate benefit only if no services other than exam and x-rays were performed on the same tooth during the visit.
Palliative Treatment (relief of pain)	80%	Covered as a separate benefit only if no services other than exam and x-rays were performed on the same tooth during the visit
General Anesthesia	80%	Covered only for patients under age 7 or who are physically or developmentally disabled
Occlusal Guards	80%	For habitual grinding, 1 per 60 consecutive months
Diagnostic Casts	80%	1 time per 24 consecutive months

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Pin Retention	80%	2 pins per tooth, not covered in addition to cast restoration
Root Canal Treatment	80%	
Post and Core	80%	Covered only for a tooth that has had root canal therapy
Scaling and Root Planing	80%	1 time per quadrant per consecutive 24 months
Periodontal Surgery	80%	1 time per consecutive 36 months per surgical area
Osseous Grafts	80%	1 time per consecutive 36 months per quadrant or surgical site
Periodontal Maintenance	80%	2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement
Full Mouth Debridement	80%	1 time per consecutive 36 months
Simple Extraction	80%	
Surgical Extraction, including impacted wisdom teeth	80%	

Covered Services	Plan Pays:*	Benefit Limitations
Part C Services: Major Services		
Crowns, Inlays, Onlays	50%	1 time per tooth per consecutive 60 months
Fixed Bridges	50%	1 time per tooth per consecutive 60 months. Alternate benefits for a partial denture may be applied
Full Dentures	50%	1 time per consecutive 60 months. No allowance for overdentures or customized dentures.
Partial Dentures	50%	1 time per consecutive 60 months. No allowance for precision or semi-precision attachments.
Recement Crowns, Inlays, Onlays, Bridges	50%	1 time per 6 months per restoration
Relining and Rebasing Dentures	50%	1 time per consecutive 12 months, and more than 6 months after initial insertions
Repairs to Bridges, Full Dentures, Partial Dentures	50%	Repairs and adjustments more than 12 months after initial insertion

Covered Services	Plan Pays:*	Benefit Limitations
Orthodontic Services		
Diagnose and correct misalignment of the teeth or bite	50%	Course of treatment is typically 24 months, with initial payment at banding of 20% and remaining payment spread equally over the course of treatment.

***Your Plan Benefits are based on who provides your dental services.**

If you see a Participating Provider, your Plan Benefits are based on MAC. MAC stands for Maximum Allowable Charge, which is a discounted fee negotiated between us and a Participating Provider. There is usually a difference between the amount your Provider actually charges for a service, and how much of that billed charge the Provider has agreed to accept as payment in full for services under a Participating Provider contract. If you see a Participating Provider, your plan pays a percentage of MAC, and you are not responsible for any billed amounts above the MAC allowance.

If you see a Nonparticipating Provider, your Plan Benefits are based on MAA: MAA stands for Maximum Allowable Amount. There is usually a difference between the amount your Provider actually charges for a service, and how much of that billed charge we allow as the Maximum Allowable Amount. Your plan pays a percentage of the MAA rather than a percentage of the billed charge. If your Provider charges more than the MAA, you are responsible for the difference between the billed charge and the MAA.

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