Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: ***Health Net Life Insurance Company***
Policy Type: ***PPO*** **& EPO**
Effective Date:

Plan Name: ***Individual & Family Plans - Adult Dental***
Insurer Phone #: 1-*866-249-2382 (TTY: 711)*
Insurer Website: ***www.healthnet.com***

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT www.healthnet.com OR CALL 1-866-249-2382 (TTY: 711).

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-Of-Network
Dental	$50/Per Individual	

• **The deductible applies to all services except Diagnostic and Preventive.**
• A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
• **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
• **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-Of-Network
Annual Maximum	$1,000	
Lifetime Maximum for Orthodontia	Not Applicable	Not Applicable

• **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.

• **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. There is a three-month waiting period for Basic Services and a six-month waiting period for Major Services.

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Diagnostic	$13	$13	Limited to 2 per 12 month period
Bitewing X-ray	Diagnostic	$21	$21	Limited to 1 per 12 month period
Cleaning	Preventive	$32	$32	Limited to 2 per 12 month period
Filling	Basic	$22	$22	Limited to 1 in a 12 month period
Simple Extraction	Basic	$22	$22	Limited to 1 time per tooth per lifetime
Root Canal	Basic	$121	$121	Limited to 1 per tooth per lifetime
Scaling and Root Planing	Basic	$23	$23	Limited to 1 time per quadrant per 24 month period
Ceramic Crown	Major	$248	$248	Limited to once in a 5 year period
Removable Partial Denture	Major	$88	$88	Limited to once in a 5 year period
Orthodontia	Not Covered	Not Covered		Not Covered

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $250 Out-of-Network: $450	Total Cost of Care	In-network: $150 Out-of-Network: $250	Total Cost of Care	In-network: $950 Out-of-Network: $1,400
Deductible	In-network: $50 Out-of-Network: $50	Deductible	In-network: $50 Out-of-Network: $50	Deductible	In-network: $50 Out-of-Network: $50
Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-Network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-Network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-Network: $1,000
Patient Cost (copayment or coinsurance)	In-network: $66 Out-of-Network: $66	Patient Cost (copayment or coinsurance)	In-network: $22 Out-of-Network: $22	Patient Cost (copayment or **coinsurance**)	In-network: $248 Out-of-Network: $248
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $66 Out-of-Network: $66**	**In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $72 Out-of-Network: $72**	**In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $298 Out-of-Network: $298**
Summary of what is not covered or subject to limitation:	Limited to 2 per 12 month period	Summary of what is not covered or subject to limitation:	Limited to 1 in a 12 month period	Summary of what is not covered or subject to limitation:	Limited to once in a 5 year period