

# Classic Plus 1 2000 with MaxAdvantage<sup>1</sup>

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)                                         | (out-of-network) <sup>2</sup>                        |
| <b>Calendar year maximum that plan pays</b>                                                                                                                                                                                                                            | \$2000                                               |                                                      |
| <b>Deductible</b>                                                                                                                                                                                                                                                      | \$50 single/\$150 family                             | \$75 single/\$225 family                             |
| <b>Diagnostic</b>                                                                                                                                                                                                                                                      |                                                      |                                                      |
| 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)                                    |
| <b>Preventive</b>                                                                                                                                                                                                                                                      |                                                      |                                                      |
| 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)                                    |
| <b>Prenatal Dental care</b><br>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)                                    |
| <b>Restorative treatment</b>                                                                                                                                                                                                                                           |                                                      |                                                      |
| D2150 Amalgam (silver filling) – two surfaces                                                                                                                                                                                                                          | 10% (after ded.)                                     | 20% (after ded.)                                     |
| D2331 Composite (white filling) – two surfaces anterior                                                                                                                                                                                                                | 10% (after ded.)                                     | 20% (after ded.)                                     |
| D2392 Composite (white filling) – two surfaces posterior                                                                                                                                                                                                               | 10% (after ded.)                                     | 20% (after ded.)                                     |
| <b>Crowns and pontics</b>                                                                                                                                                                                                                                              |                                                      |                                                      |
| D2751 Crown – porcelain fused to predominantly base metal                                                                                                                                                                                                              | 40% (after ded.)                                     | 50% (after ded.)                                     |
| D2962 Labial veneer (porcelain laminate) – laboratory                                                                                                                                                                                                                  | 40% (after ded.)                                     | 50% (after ded.)                                     |
| <b>Endodontics</b>                                                                                                                                                                                                                                                     |                                                      |                                                      |
| D3320 Root canal – bicuspid (ex. final restoration)                                                                                                                                                                                                                    | 10% (after ded.)                                     | 20% (after ded.)                                     |
| D3330 Root canal – molar (ex. final restoration)                                                                                                                                                                                                                       | 10% (after ded.)                                     | 20% (after ded.)                                     |
| <b>Periodontics</b>                                                                                                                                                                                                                                                    |                                                      |                                                      |
| D4341 Periodontal scaling and root planning – 4 or more teeth per quadrant                                                                                                                                                                                             | 10% (after ded.)                                     | 20% (after ded.)                                     |
| <b>Prosthodontics</b>                                                                                                                                                                                                                                                  |                                                      |                                                      |
| D5110 Complete denture – upper                                                                                                                                                                                                                                         | 40% (after ded.)                                     | 50% (after ded.)                                     |
| <b>Implants</b>                                                                                                                                                                                                                                                        |                                                      |                                                      |
| D6010 Surgical placement of implant body – endosteal implant                                                                                                                                                                                                           | 50% after deductible / \$1,500 calendar year maximum | 50% after deductible / \$1,500 calendar year maximum |
| <b>Oral Surgery</b>                                                                                                                                                                                                                                                    |                                                      |                                                      |
| D7220 Removal of impacted tooth – soft tissue                                                                                                                                                                                                                          | 10% (after ded.)                                     | 20% (after ded.)                                     |
| <b>Orthodontics</b>                                                                                                                                                                                                                                                    |                                                      |                                                      |
| D8070-90 Comprehensive orthodontic treatment – adult or child                                                                                                                                                                                                          | 50% after deductible/\$1,500 lifetime maximum        | 50% after deductible/\$1,500 lifetime maximum        |
| <b>Other general services</b>                                                                                                                                                                                                                                          |                                                      |                                                      |
| D9972 External bleaching (teeth whitening) – per arch                                                                                                                                                                                                                  | Not covered                                          | Not covered                                          |

<sup>1</sup>Health Net Dental PPO plans, are offered and serviced by Dental Benefit Providers of California, Inc. (DBP). Obligations of DBP are neither the obligations of, nor guaranteed by, Health Net, LLC. or its affiliates.

<sup>2</sup>Out-of-network benefits are reimbursed at the Usual, Customary and Reasonable (UCR) amounts as determined by Fair Health, Inc.

## 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. Classic Plus 1 2000 with MaxAdvantage excluded.
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. Any 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 prophylaxis 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 cannot 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 cytology 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 planning (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 relining 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.