



Dental Preferred Plus DP50-1855-1500¹

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) ²
Calendar year maximum that plan pays	\$1500	
Deductible	\$50 Single/\$150 Family	\$50 Single/\$150 Family
Diagnostic		
D0120 Periodic oral evaluation	\$0 (ded. waived)	20% (ded. waived)
D0150 Comprehensive oral evaluation	\$0 (ded. waived)	20% (ded. waived)
D0210 Intraoral X-rays – complete series	\$0 (ded. waived)	20% (ded. waived)
Preventive		
D1110 Prophylaxis (2 cleanings per year) – adult	\$0 (ded. waived)	20% (ded. waived)
D1110 Additional prophylaxis (maximum of 2 additional per year) – adult	Not Covered	Not Covered
D1206 Topical application of fluoride	\$0 (ded. waived)	20% (ded. waived)
Restorative treatment		
D2150 Amalgam (silver filling) – two surfaces	20% (after ded.)	40% (after ded.)
D2331 Composite (white filling) – two surfaces anterior	20% (after ded.)	40% (after ded.)
D2392 Composite (white filling) – two surfaces posterior	20% (after ded.)	40% (after ded.)
Crowns and pontics		
D2751 Crown – porcelain fused to predominantly base metal	50% (after ded.) ³	50% (after ded.) ³
D2962 Labial veneer (porcelain laminate) – laboratory	50% (after ded.) ³	50% (after ded.) ³
Endodontics		
D3320 Root canal – bicuspid (ex. final restoration)	20% (after ded.)	40% (after ded.)
D3330 Root canal – molar (ex. final restoration)	20% (after ded.)	20% (after ded.)
Periodontics		
D4341 Periodontal scaling and root planning – 4 or more teeth per quadrant	20% (after ded.)	20% (after ded.)
Prosthodontics		
D5110 Complete denture – upper	50% (after ded.) ³	50% (after ded.) ³
Implants		
D6010 Surgical placement of implant body – endosteal implant	50% (after ded.) ³	50% (after ded.) ³
Oral Surgery		
D7220 Removal of impacted tooth – soft tissue	20% (after ded.)	20% (after ded.)
Orthodontics		
D8070-90 Comprehensive orthodontic treatment – adult or child	50% deductible waived/\$1,500 lifetime maximum ³	50% deductible waived/\$1,500 lifetime maximum ³
Other general services		
D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

¹Dental benefits are underwritten by Health Net. Dental benefits are administered by Dental Benefit Providers, Inc. Dental Benefit Providers, Inc. is not affiliated with Health Net Health Plan of Oregon, Inc.

²Out-of-network benefits are reimbursed at the Reasonable & Customary amount (R&C). The R&C amounts are those that are compared with similar services within the same geographic service area.

³6 month waiting period. Waiting period is waived if group had prior dental coverage including major services and orthodontia. Prior proof required.



Dental Plus D25-1855-1500¹

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Covered procedures (partial list)	Member responsibility	
	(in-network)	(out-of-network) ²
Calendar year maximum that plan pays	\$1500	
Deductible	\$25 Single/\$75 Family	\$25 Single/\$75 Family
Diagnostic		
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)
Preventive		
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)
Restorative treatment		
D2150 Amalgam (silver filling) – two surfaces	20% (after ded.)	20% (after ded.)
D2331 Composite (white filling) – two surfaces anterior	20% (after ded.)	20% (after ded.)
D2392 Composite (white filling) – two surfaces posterior	20% (after ded.)	20% (after ded.)
Crowns and pontics		
D2751 Crown – porcelain fused to predominantly base metal	50% (after ded.) ³	50% (after ded.) ³
D2962 Labial veneer (porcelain laminate) – laboratory	50% (after ded.) ³	50% (after ded.) ³
Endodontics		
D3320 Root canal – bicuspid (ex. final restoration)	20% (after ded.)	20% (after ded.)
D3330 Root canal – molar (ex. final restoration)	20% (after ded.)	20% (after ded.)
Periodontics		
D4341 Periodontal scaling and root planning – 4 or more teeth per quadrant	20% (after ded.)	20% (after ded.)
Prosthodontics		
D5110 Complete denture – upper	50% (after ded.) ³	50% (after ded.) ³
Implants		
D6010 Surgical placement of implant body – endosteal implant	50% (after ded.) ³	50% (after ded.) ³
Oral Surgery		
D7220 Removal of impacted tooth – soft tissue	20% (after ded.)	20% (after ded.)
Orthodontics		
D8070-90 Comprehensive orthodontic treatment – adult or child	50% deductible waived/\$1,500 lifetime maximum ³	50% deductible waived/\$1,500 lifetime maximum ³
Other general services		
D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

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³6 month waiting period. Waiting period is waived if group had prior dental coverage including major services and orthodontia. Prior proof required.



Dental Plus D50-1855-1500¹

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) ²
Calendar year maximum that plan pays	\$1500	
Deductible	\$50 Single/\$150 Family	\$50 Single/\$150 Family
Diagnostic		
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)
Preventive		
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)
Restorative treatment		
D2150 Amalgam (silver filling) – two surfaces	20% (after ded.)	20% (after ded.)
D2331 Composite (white filling) – two surfaces anterior	20% (after ded.)	20% (after ded.)
D2392 Composite (white filling) – two surfaces posterior	20% (after ded.)	20% (after ded.)
Crowns and pontics		
D2751 Crown – porcelain fused to predominantly base metal	50% (after ded.) ³	50% (after ded.) ³
D2962 Labial veneer (porcelain laminate) – laboratory	50% (after ded.) ³	50% (after ded.) ³
Endodontics		
D3320 Root canal – bicuspid (ex. final restoration)	20% (after ded.)	20% (after ded.)
D3330 Root canal – molar (ex. final restoration)	20% (after ded.)	20% (after ded.)
Periodontics		
D4341 Periodontal scaling and root planning – 4 or more teeth per quadrant	20% (after ded.)	20% (after ded.)
Prosthodontics		
D5110 Complete denture – upper	50% (after ded.) ³	50% (after ded.) ³
Implants		
D6010 Surgical placement of implant body – endosteal implant	50% (after ded.) ³	50% (after ded.) ³
Oral Surgery		
D7220 Removal of impacted tooth – soft tissue	20% (after ded.)	20% (after ded.)
Orthodontics		
D8070-90 Comprehensive orthodontic treatment – adult or child	50% deductible waived/\$1,500 lifetime maximum ³	50% deductible waived/\$1,500 lifetime maximum ³
Other general services		
D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

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³6 month waiting period. Waiting period is waived if group had prior dental coverage including major services and orthodontia. Prior proof required.



Dental Plus D100-1855-1000¹

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) ²
Calendar year maximum that plan pays	\$1000	
Deductible	\$100 Single/\$300 Family	\$100 Single/\$300 Family
Diagnostic		
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)
Preventive		
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)
Restorative treatment		
D2150 Amalgam (silver filling) – two surfaces	20% (after ded.)	20% (after ded.)
D2331 Composite (white filling) – two surfaces anterior	20% (after ded.)	20% (after ded.)
D2392 Composite (white filling) – two surfaces posterior	20% (after ded.)	20% (after ded.)
Crowns and pontics		
D2751 Crown – porcelain fused to predominantly base metal	50% (after ded.) ³	50% (after ded.) ³
D2962 Labial veneer (porcelain laminate) – laboratory	50% (after ded.) ³	50% (after ded.) ³
Endodontics		
D3320 Root canal – bicuspid (ex. final restoration)	20% (after ded.)	20% (after ded.)
D3330 Root canal – molar (ex. final restoration)	20% (after ded.)	20% (after ded.)
Periodontics		
D4341 Periodontal scaling and root planning – 4 or more teeth per quadrant	20% (after ded.)	20% (after ded.)
Prosthodontics		
D5110 Complete denture – upper	50% (after ded.) ³	50% (after ded.) ³
Implants		
D6010 Surgical placement of implant body – endosteal implant	50% (after ded.) ³	50% (after ded.) ³
Oral Surgery		
D7220 Removal of impacted tooth – soft tissue	20% (after ded.)	20% (after ded.)
Orthodontics		
D8070-90 Comprehensive orthodontic treatment – adult or child	50% deductible waived/\$1,000 lifetime maximum ³	50% deductible waived/\$1,000 lifetime maximum ³
Other general services		
D9972 External bleaching (teeth whitening) – per arch	Not Covered	Not Covered

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²Out-of-network benefits are reimbursed at the Reasonable & Customary amount (R&C). The R&C amounts are those that are compared with similar services within the same geographic service area.

³6 month waiting period. Waiting period is waived if group had prior dental coverage including major services and orthodontia. Prior proof required.

Exclusion and Limitations

General Exclusions

1. Services that are not Necessary Dental Care, other than covered preventive services.
2. Any procedure not performed in a dental setting.
3. Benefits not stated; services and supplies not specifically listed as covered; Benefits in excess of the stated limits under this Agreement.
4. Expenses for a Procedure in Progress begun prior to the Member's eligibility. Dental Services rendered after the date a Member's coverage terminates.
5. Conditions caused by or arising out of war or acts of war, declared or undeclared. To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of a basic or supplemental dental service in accordance with the requirements of this Agreement, we are required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this provision, an event is not within our control if we cannot exercise influence or dominion over its occurrence.
6. Hospitalization or other facility charges.
7. Services and supplies for which the Member is not required to pay or that the Member would receive at no cost in the absence of dental coverage; services and supplies for which the Member is not billed by a Provider or for which we are billed a zero dollar charge.
8. Services and supplies rendered by an immediate family member (spouse, Domestic Partner, parent, child, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by an immediate family member of the Member; Member self-treatment, including but not limited to self-prescribed medications and medical self-ordered services and laboratory tests.
9. Cosmetic Procedures.
10. Non-emergency services provided outside the United States.
11. 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.
12. Pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
13. Procedures that are considered to be Experimental or Investigational. The fact that an Experimental or Investigational 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 or Investigational for that particular condition.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
16. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
17. Treatment of malignant or benign neoplasms, cysts or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
18. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
19. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery, including that related to the temporomandibular joint.
20. Orthognathic surgery and jaw alignment; gnathologic recordings.
21. Drugs and medications obtainable with or without a prescription, unless dispensed and utilized in the dental office during the patient visit.
22. Occlusal guards prescribed for purposes other than habitual grinding, including those used as safety equipment or to affect performance or for protection in sports-related activities.
23. Acupuncture, acupressure, and other forms of alternative treatment.
24. Educational programs, services and supplies to teach nutritional and oral hygiene techniques.
25. Charges for failure to keep a scheduled appointment.
26. Replacement of appliances and repeated procedures that are related to Provider error. These replacements services are the responsibility of the Provider.
27. Replacement of appliances and repeated procedures that are related to patient noncompliance, loss, or theft. These replacements and services are the responsibility of the patient.
28. Services for any illness, condition, or injury occurring in or arising out of the course of employment for which a claim has been approved under workers' compensation insurance coverage.
29. Orthodontic services, except extractions, unless specifically covered by your dental Benefit Schedule.

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–D0170, 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 panoramic radiographs (ADA codes D0210, D0277, D0330 and D0387) are limited to 1 time per consecutive 36 months. Exception to the 36-month limit on panoramic 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. Panoramic, Cephalometric & Intraoral Radiographs (D0701, D0702, D0709) are limited to 1 time per consecutive 36 months

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. Dental prophylaxis (ADA codes D1110 and D1120) is limited to 2 times per 12 consecutive months.
7. Diagnostic casts (ADA code D0470) limited to 1 time per consecutive 24 months.
8. 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.
9. Sealants (ADA code D1351-D1353) limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
10. Space maintainers (ADA codes D1510, , D1516, D1517, D1520, , 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.
11. Re-cement space maintainers (ADA code D1551-D1553) is limited to 1 per consecutive 6 months after initial insertion.
12. Multiple restorations on one surface (ADA codes D2140, D2330 and D2391) will be treated as a single filling.
13. 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.)
14. 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. D2510 – D2530, D2610 – D2630, D2650 – D2652 & D2642 – D2644 Alt Benefit.
15. Recement Inlays/Onlays (D2910), Crowns (D2920), Bridges (D6930) and Post and Core (D2915) are limited to those performed more than 12 months after the initial insertion. Recements of inlays, onlays, post and cores and crowns are limited to 1 time per consecutive 12 months. Recements of bridges are limited to 1 time per consecutive 6 months.
16. Crowns (ADA codes D2390, D2710–D2792, D2794, , D2930–D2934) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth, not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. Prefabricated Esthetic Coated Stainless Steel Crown (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). D2710, D2720, D2740, D2750, D2780, D2783, D2790 & D2794 Alt Benefit.
17. 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). D2710, D2720, D2740, D2750, D2780, D2790 & D2794 Alt Benefit.
18. Posts and cores (ADA codes D2952–D2954, and D2957) are covered only for teeth that have had root canal therapy. *Limited to 1 per 60 consecutive months.* D2952 & D2953 Alt Benefit.
19. Protective Restorations (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.
20. Therapeutic pulpotomy (ADA code D3220) and pulpal therapy (resorbable filling) (ADA codes D3230 and D3240) are limited to 1 time per tooth per lifetime.
21. Pulpal debridement and Partial Pulpotomy for Apexogenesis (ADA code D3221) and D3222) are limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
22. 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. Retreatment of Root Canals is limited to 1 time per lifetime.
23. Apexification (D3351, D3352, D3353), Pulpal Regeneration (D3355, D3356, D3357) Apicoectomy (D3410, D3421, D3425), Retrograde filling (D3430), Root Resection/Amputation (D3450) are limited to 1 time per tooth per lifetime. Apicoectomy – each additional not (D3426) and is limited to 2 times per tooth per lifetime.
- Surgical Repair of Root Resorption (D3471-D3473) is limited to 1 time per tooth per lifetime, Surgical Exposure of Root Surface without Apicoectomy (D3501-D3503) are limited to 2 times per tooth lifetime.
24. Hemisection (ADA code D3920) is limited to 1 time per tooth per lifetime.
25. Scaling and root planning (ADA codes D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
26. Localized delivery of antimicrobial agents (ADA code D4381) is limited to 3 sites per quadrant or 12 sites total per lifetime for refractory pockets or in conjunction with periodontal scaling and root planing (ADA codes D4341 and D4342).
27. 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).
28. Complete dentures (ADA codes D5110 and D5120), immediate dentures (ADA codes D5130 and D5140), and overdenture (ADA code D5863–D5866) are limited to 1 per consecutive 60 months.
29. Partial dentures (ADA codes D5211–D5214), fixed partial denture pontics (ADA codes D6205–D6252). Fixed partial denture retainers– inlays/onlays (ADA codes D6545–D6634) and fixed partial denture retainer–crowns (ADA codes D6710–D6794) are limited to 1 per consecutive 60 months. Sectioning D9120 & Overdentures D5864 & D5866 are limited to 1 per consecutive 60 months.
30. Relining and rebasing dentures (ADA codes D5710–D5765) is limited to relining/rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.
31. Repairs and adjustments to full dentures (ADA codes D5410, D5411, D5511-D5512 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. Reattachment of tooth fragment incisal edge or cusp (D2921) is limited to 1 per consecutive 6 months.
32. Tissue conditioning – maxillary or mandibular (ADA codes D5850 and

- D5851) is limited to 1 per consecutive 12 months.
33. Tooth reimplantation and/or transplantation services (ADA codes D7270 and D7272) is limited to 1 per site per lifetime.
 34. Biopsy (ADA codes D7287–D7288) is limited to 1 biopsy per site per visit.
 35. Vestibuloplasty (ADA codes D7340 and D7350) is limited to 1 time per site per consecutive 60 months.
 36. Surgical incision (ADA codes D7510–D7521) is limited to 1 time per site per visit.
 37. 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.
 38. 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.
 39. Full mouth debridement (ADA code D4355) is limited to 1 time per consecutive 36 months.
 40. Deep Sedation/General Anesthesia (D9223), Deep sedation/general anesthesia – first 15 minutes (D9222). Evaluation for deep sedation or general anesthesia (D9219) Limitation of 4 evaluations per consecutive 12 months.
 41. 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–D4211), 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 graft (ADA code D4264), surgical revision procedure, per tooth (ADA code D4268), and distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) (ADA code D4274).
 42. Replacement of complete or partial dentures (fixed and removable) (ADA codes D5110– D5214, D5225–D5226, D5282–D5283, D6210–D6252, 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. Complete dentures (D5110 & D5120), Immediate Dentures (D5130 & D5140), and Overdentures (D5863 & D5865) are limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
 43. Exposure of an Unerrupted Tooth (D7280) is limited to 1 time per tooth per lifetime.
 44. 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.
 45. Excision of hyperplastic tissue or pericoronal gingivitis (ADA codes D7970 and D7971) is limited to 1 per site per consecutive 36 months.
 46. 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.
 47. 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.
 48. Local anesthesia. Not covered in conjunction with operative or surgical procedure.
 49. Consultation. Not covered if done with exams or professional visits.