Expanding the Benefits Horizon®

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NOTES:

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Patient Name: GABRIELLE HENDERSON
Effective Date: 12/01/2021
Policy Certificate Number: 02113886
Coverage Status: Currently Active

Calendar Year Maximum: $1500.00 per covered insured
Calendar Year Deductible: $50.00 per covered insured up to $150.00 per family
(Deductible does not apply to preventive expenses)

The above listed policy provides benefits for covered services based on a percentage of the usual and customary charges of the service region as follows:

Category of Expense	% of Covered Expenses	Waiting Period (in Months)
Preventative Expenses	100% of UCR	0
Radiographs – FMX Expenses	80% of UCR	0
Basic Expenses	80% of UCR	0
Basic Restorative Expenses	**80% of UCR**	**0**
Major Expenses	40% of UCR	12
Endodontic Expenses	40% of UCR	12
Periodontic Expenses	40% of UCR	12
Prosthodontic Repair Expenses	40% of UCR	12
Oral Surgery Expenses	40% of UCR	12

The frequencies for services are as follows:

Service	Frequency
Prophys/Cleanings	Once every 6 months
Exams	**2 per 12 month period**
Bitewings	Once per 12 month period
Full Mouth X-Rays and Panoramics	Once every 5 years
Crowns and Bridges	Once every 7 years (per tooth)
Partials and Dentures	Once every 5 years

This policy does have a missing tooth clause.
TMJ services are not covered.
Orthodontic treatment is not covered.
Implants placement, removal and all related services are not covered.

Claims May be submitted to our office via:

Electronically:	**Mail to:**	**Fax to:**
Payor ID: 60801	American Public Life P.O. Box 248950 Oklahoma City, OK 73124 - 8950	1.877.365.9423 ATTN: Claims Department

Please note that any verification of coverage provided in this correspondence does not constitute a guarantee of payment. This correspondence in no way alters or amends the policy contract. For a complete list of exclusions, conditions, terms, and limitations, please contact our office at 1.800.256.8606.

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SCHEDULE OF COVERED DENTAL SERVICES AND PROCEDURES

PROCEDURE CODE	SERVICE	LIMITATION
	PREVENTIVE EXPENSES	
00120	Periodic oral evaluation	(u)
00150	Comprehensive oral evaluation – new or established patient	(u)
00270	Bitewing – single film	(v)
00272	Bitewing – two films	(v)
00274	Bitewing – four films	(v)
01110	Prophylaxis – adult	(a)
01120	Prophylaxis – child	(a) (e)
01201	Topical application of fluoride (including prophylaxis) – child	(e) (d)
01203	Topical application of fluoride (prophylaxis not included) – child	(e) (d)
01204	Topical application of fluoride (prophylaxis not included) – adult	(c) (d)
01205	Topical application of fluoride (including prophylaxis) – adult	(c) (d)
01351	Sealant – per tooth	(b) (g) (e)
01510	Space maintainer – fixed unilateral	(e) (bb)
01515	Space maintainer – fixed – bilateral	(e) (bb)
01520	Space maintainer – removable – unilateral	(e) (bb)
01525	Space maintainer – removable – bilateral	(e) (bb)
01550	Re – cementation of space maintainer	(z)
	RADIOGRAPHS – FMX EXPENSES	
00210	Intraoral – complete series (including bitewings)	(ff)
00330	Panoramic film	(ff)
	BASIC EXPENSES	
00140	Limited oral evaluation – problem focused	(u)
00160	Detailed and extensive oral evaluation – problem focused, by report	(u)
00220	Intraoral – periapical first film	
00230	Intraoral – periapical each additional film	
00240	Intraoral – occlusal film	
00250	Extraoral – first film	
00260	Extraoral – each additional film	
00277	Vertical bitewings – 7 to 8 films	(ff)
00290	Posterior – anterior or lateral skull and facial bone survey film	
00310	Sialography	
00415	Bacteriologic studies for determination of pathologic agent	
00460	Pulp vitality tests	
00472	**Accession of tissue, gross examination, preparation and transmission of written report**	
07111	Coronal remnants – deciduous tooth	(r)
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	(r)
09110	Palliative (emergency) treatment of dental pain – minor procedure	
09310	**Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)**	
	BASIC RESTORACTIVE EXPENSES	
02140	Amalgam – one surface, primary or permanent	(o) (l)
02150	Amalgam – two surfaces, primary or permanent	(o) (l)

PROCEDURE CODE	SERVICE	LIMITATION
02160	Amalgam – three surfaces, primary or permanent	(o) (l)
02161	Amalgam – four or more surfaces, primary or permanent	(o) (l)
02330	Resin – based composite – one surface, anterior	(o) (l)
02331	Resin – based composite – two surfaces, anterior	(o) (l)
02332	Resin – based composite – three surfaces, anterior	(o) (l)
02335	Resin – based composite – four or more surfaces or involving incisal angles (anterior)	(o) (l)
02391	Resin – based composite – one surface, posterior	(o) (l)
02392	Resin – based composite – two surfaces, posterior	(o) (l)
02393	Resin – based composite –three surfaces, posterior	(o) (l)
02394	Resin – based composite – four or more surfaces, posterior	(o) (l)
02410	Gold foil – one surface	(o) (l)
02420	Gold foil – two surfaces	(o) (l)
02430	Gold foil – three surfaces	(o) (l)
02940	Sedative Filling	(o) (l)
02951	Pin retention – per tooth, in addition to restoration	(o) (l)
	MAJOR EXPENSES	
02510	Inlay – metallic – one surface	(aa) (dd)
02520	Inlay – metallic – two surfaces	(aa) (dd)
02530	Inlay - metallic – three or more surfaces	(aa) (dd)
02542	Onlay – metallic – two surfaces	(aa) (dd)
02543	Onlay – metallic – three surfaces	(aa) (dd)
02544	Onlay – metallic – four or more surfaces	(aa) (dd)
02610	Inlay – porcelain/ceramic – one surface	(aa) (dd)
02620	Inlay – porcelain/ceramic – two surfaces	(aa) (dd)
02630	Inlay – porcelain/ceramic – three or more surfaces	(aa) (dd)
02642	Onlay – porcelain/ceramic – two surfaces	(aa) (dd)
02643	Onlay – porcelain/ceramic – three surfaces	(aa) (dd)
02644	Onlay – porcelain/ceramic – four or more surfaces	(aa) (dd)
02650	Inlay – resin-based composite – one surface	(aa) (dd)
02651	Inlay – resin-based composite – two surfaces	(aa) (dd)
02652	Inlay – resin-based composite – three or more surfaces	(aa) (dd)
02662	Onlay – resin-based composite – two surfaces	(aa) (dd)
02663	Onlay – resin-based composite – three surfaces	(aa) (dd)
02664	Onlay – resin-based composite – four or more surfaces	(aa) (dd)
02910	Recement inlay	(z)
02710	Crown – resin (indirect)	(aa) (dd)
02720	Crown – resin with high noble metal	(aa) (dd)
02721	Crown – resin with predominantly base metal	(aa) (dd)
02722	Crown – resin with noble metal	(aa) (dd)
02740	Crown – porcelain/ceramic substrate	(aa) (dd)
02750	Crown – porcelain fused to high noble metal	(aa) (dd)
02751	Crown – porcelain fused to predominantly base metal	(aa) (dd)
02752	Crown – porcelain fused to noble metal	(aa) (dd)
02780	Crown – ¾ cast high noble metal	(aa) (dd)
02781	Crown – ¾ cast predominantly base metal	(aa) (dd)

PROCEDURE CODE	SERVICE	LIMITATION
02782	Crown – ¾ cast noble metal	(aa) (dd)
02790	Crown – full cast high noble metal	(aa) (dd)
02791	Crown – full cast predominantly base metal	(aa) (dd)
02792	Crown – full cast noble metal	(aa) (dd)
02920	Recement crown	(aa) (dd)
02930	Prefabricated stainless steel crown – primary tooth	(aa) (w)
02931	Prefabricated stainless steel crown – permanent tooth	(aa) (w)
02932	Prefabricated resin crown	(aa) (w)
02933	Prefabricated stainless steel crown with resin window	(aa) (w)
02950	Core buildup, including any pins	(aa) (dd)
02952	Cast post and core in addition to crown	(aa) (dd)
02954	Prefabricated post and core in addition to crown	(aa) (dd)
02970	Temporary crown (fractured tooth)	(aa) (dd)
02980	Crown repair, by report	(d) (z)
05110	Complete denture – maxillary	(cc)
05120	Complete denture – mandibular	(cc)
05130	Immediate denture – maxillary	(cc)
05140	Immediate denture – mandibular	(cc)
05211	Maxillary partial denture – resin base (including any conventional clasps, rests and	(cc)
05212	Mandibular partial denture – resin base (including any conventional clasps, rests and	(cc)
05213	Maxillary partial denture – cast metal framework with resin denture bases (including	
05214	Mandibular partial denture – cast metal framework with resin denture bases	(cc)
05281	Removable unilateral partial denture – one piece cast metal (including clasps and	(cc)
05410	Adjust complete denture – maxillary	(a) (z)
05411	Adjust complete denture – mandibular	(a) (z)
05421	Adjust partial complete denture – maxilliary	(a) (z)
05422	Adjust partial denture – mandibular	(a) (z)
05850	Tissue conditioning, maxillary	(j) (z)
05851	Tissue conditioning, mandibular	(j) (z)
06210	Pontic – cast high noble metal	(aa) (dd)
06211	Pontic – cast predominantly base metal	(aa) (dd)
06212	Pontic – cast noble metal	(aa) (dd)
06240	Pontic – porcelain fused to high noble metal	(aa) (dd)
06241	Pontic – porcelain fused to predominantly base metal	(aa) (dd)
06242	Pontic – porcelain fused to noble metal	(aa) (dd)
06245	Pontic – porcelain/ceramic	(aa) (dd)
06250	Pontic – resin with high noble metal	(aa) (dd)
06251	Pontic – resin with predominantly base metal	(aa) (dd)
06252	Pontic – resin with noble metal	(aa) (dd)
06545	Retainer – cast metal for resin bonded fixed prostheses	(aa) (dd)
06600	Inlay – porcelain/ceramic, two surfaces	(aa) (dd)
06601	Inlay – porcelain/ceramic, three or more surfaces	(aa) (dd)

PROCEDURE CODE	SERVICE	LIMITATION
06602	Inlay – cast high noble metal, two surfaces	(aa) (dd)
06603	Inlay – cast high noble metal, three or more surfaces	(aa) (dd)
06604	Inlay – cast predominantly base metal, two surfaces	(aa) (dd)
06605	Inlay – cast predominantly base metal, three or more surfaces	(aa) (dd)
06606	Inlay – cast noble metal, two surfaces	(aa) (dd)
06607	Inlay – cast noble metal, three or more surfaces	(aa) (dd)
06608	Onlay – porcelain/ceramic, two surfaces	(aa) (dd)
06609	Onlay – porcelain/ceramic, three or more surfaces	(aa) (dd)
06610	Onlay – cast high noble metal, two surfaces	(aa) (dd)
06611	Onlay – cast high noble metal, three or more surfaces	(aa) (dd)
06612	Onlay – cast predominantly base metal, two surfaces	(aa) (dd)
06613	Onlay – cast predominantly base metal, three or more surfaces	(aa) (dd)
06614	Onlay – cast noble metal, two surfaces	(aa) (dd)
06615	Onlay – cast noble metal, three or more surfaces	(aa) (dd)
06720	Crown – resin with high noble metal	(aa) (dd)
06721	Crown – resin with predominantly base metal	(aa) (dd)
06722	Crown – resin with noble metal	(aa) (dd)
06740	Crown – porcelain/ceramic	(aa) (dd)
06750	Crown – porcelain fused to high noble metal	(aa) (dd)
06751	Crown – porcelain fused to predominantly base metal	(aa) (dd)
06752	Crown – porcelain fused to noble metal	(aa) (dd)
06780	Crown – ¾ cast high noble metal	(aa) (dd)
06781	Crown – ¾ cast predominantly base metal	(aa) (dd)
06782	Crown – ¾ cast noble metal	(aa) (dd)
06783	Crown – ¾ cast porcelain/ceramic	(aa) (dd)
06790	Crown – full cast high noble metal	(aa) (dd)
06791	Crown – full cast predominantly base metal	(aa) (dd)
06792	Crown – full cast noble metal	(aa) (dd)
06930	Recement fixed partial denture	(d) (z)
06970	Cast post and core in addition to fixed partial denture retainer	(aa) (dd)
06971	Cast post as part of fixed partial denture retainer	(aa) (dd)
06972	Prefabricated post and core in addition to fixed partial denture retainer	(aa) (dd)
06973	Core build up for retainer, including any pins	(aa) (dd)
06980	Fixed partial denture repair, by report	(d) (z)
09220	Deep sedation/general anesthesia – first 30 minutes	(t)
09221	Deep sedation/general anesthesia – each additional 15 minutes	(t)
09230	Analgesia, anxiolysis, inhalation of nitrous oxide	
09241	Intravenous conscious sedation/analgesia – first 30 minutes	(t)
09242	Intravenous conscious sedation/analgesia – each additional 15 minutes	(t)
09940	Occlusal guard, by report	(y) (aa) (x)
09951	Occlusal adjustment – limited	(y) (aa) (p)
09952	Occlusal adjustment - complete	(y) (aa) (p)

PROCEDURE CODE	SERVICE	LIMITATION
	ENDODONTIC EXPENSES	
03110	Pulp cap – direct (excluding final restoration)	
03120	Pulp cap – indirect (excluding final restoration)	
03220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	(e)
03221	Pulpal debridement, primary and permanent teeth	
03230	**Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)**	
03240	**Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)**	
03310	Anterior (excluding final restoration)	
03320	Bicuspid (excluding final restoration)	
03330	Molar (excluding final restoration)	
03351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, **root resorption, etc.)**	(r)
03352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	(r)
03353	Apexification/recalcification – final visit (apical closure/calcific repair of perforations,	(r)
03410	Apicoectomy/periradicular surgery – anterior	(r)
03421	Apicoectomy/periradicular surgery - bicuspid (first root)	(r)
03425	Apicoectomy/periradicular surgery – molar (first root)	(r)
03426	Apicoectomy/periradicular surgery (each additional root)	(r)
03430	Retrograde filling – per root	(r)
03450	Root amputation – per root	(r)
03920	Hemisection (including any root removal), not including root canal therapy	(s)
	PERIODONTIC EXPENSES	
00180	Comprehensive periodontal evaluation – new or established patient	(u)
04210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant**	**(k)**
04211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	(k)
04240	**Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant**	**(k)**
04241	Gingival flap procedure, including root planing – one to three teeth, per quadrant	(k)
04249	Clinical crown lengthening – hard tissue	(k)
04260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or	(n)
	teeth spaces per quadrant	
04261	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant	(n)
04263	Bone replacement graft – first site in quadrant	(k)
04264	Bone replacement graft – each additional site in quadrant	(k)
04270	Pedicle soft tissue graft procedure	(k)
04271	Free soft tissue graft procedure (including donor site surgery)	(k)
04273	Subepithelial connective tissue graft procedures	(k)
04274	Distal or proximal wedge procedure (when not performed in conjunction with surgical	(k)
04341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth	(k)
04342	Periodontal scaling and root planing – one to three teeth, per quadrant	(k)
04355	Full mouth debridement to enable comprehensive evaluation and diagnosis	(k)

PROCEDURE CODE	SERVICE	LIMITATION
04381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into	
04910	Periodontal maintenance	(a)
04920	Unscheduled dressing change, (by someone other than treating dentist)	
	PROSTHODONTIC REPAIR EXPENSES	
05510	Repair broken complete denture base	(d) (z)
05520	Replace missing or broken teeth – complete denture (each tooth)	(d) (z)
05610	Repair resin denture base	(d) (z)
05620	Repair cast framework	(d) (z)
05630	Repair or replace broken clasp	(d) (z)
05640	Replace broken teeth – per tooth	(d) (z)
05650	Add tooth to existing partial denture	(d) (z)
05660	Add clasp to existing partial denture	(d) (z)
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	(cc)
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	(cc)
05710	Rebase complete maxillary denture	(f) (z)
05711	Rebase complete mandibular denture	(f) (z)
05720	Rebase maxillary partial denture	(f) (z)
05721	Rebase mandibular partial denture	(f) (z)
05730	Reline complete maxillary denture (chairside)	(f) (z)
05731	Reline complete mandibular denture (chairside)	(f) (z)
05740	Reline maxillary partial denture (chairside)	(f) (z)
05741	Reline mandibular partial denture (chairside)	(f) (z)
05750	Reline complete maxillary denture (laboratory)	(f) (z)
05751	Reline complete mandibular denture (laboratory)	(f) (z)
05760	Reline maxillary partial denture (laboratory)	(f) (z)
05761	Reline mandibular partial denture (laboratory)	(f) (z)
	ORAL SURGERY EXPENSES	
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
07220	Removal of impacted tooth –soft tissue	
07230	Removal of impacted tooth – partially bony	
07240	Removal of impacted tooth – completely bony	
07241	Removal of impacted tooth – completely bony, with unusual surgical complications	
07250	Surgical removal of residual tooth roots (cutting procedure)	
07260	Oroantral fistula closure	
07261	Primary closure of a sinus perforation	
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	(s)
07285	Biopsy of oral tissue – hard (bone, tooth)	(ee)
07286	Biopsy of oral tissue – soft (all others)	(ee)
07310	Alveoloplasty in conjunction with extractions – per quadrant	(bb)
07320	Alveoloplasty not in conjunction with extractions – per quadrant	(bb)
07340	Vestibuloplasty – ridge extension (secondary epithelialization)	(s)
07350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment,	(s)
07410	Excision of benign lesion up to 1.25 cm	(ee)
07411	Excision of benign lesion greater than 1.25cm	(ee)

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PROCEDURE CODE	SERVICE	LIMITATION
07450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	(ee)
07451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	(ee)
07460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	(ee)
07461	Removal of benign nonodontogenic cyst or tumor – lesion greater than 1.25 cm	(ee)
07471	Removal of lateral exostosis (maxilla or mandible)	(s)
07472	Removal of torus palatinus	(s)
07473	Removal of torus mandibularis	(s)
07485	Surgical reduction of osseous tuberosity	(s)
07510	Incision and drainage of abscess – intraoral soft tissue	
07520	Incision and drainage of abscess – extraoral soft tissue	
07530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	
07540	Removal of reaction producing foreign bodies, musculoskeletal system	
07550	Partial ostectomy/sequestrectomy for removal of non – vital bone	
07910	Suture of recent small wound up to 5 cm	
07960	Frenulectomy (frenectomy or frenotomy) – separate procedure	(bb)
07970	Excision of hyperplastic tissue – per arch	
07971	Excision of pericoronal gingiva	
07972	Surgical reduction of fibrous tuberosity	(s)
07980	Sialolithotomy	

Key for Schedule of Covered Dental Services and Procedures

Limitations:

a) Maximum of 1 procedure per 6 months
b) Maximum of 1 procedure per 36 months
c) Limited to Dependent Children under age 19
d) Maximum of 1 procedure per 12 months
e) Limited to Dependent Children under age 14
f) Maximum of 1 procedure per 24 months
g) Applications made to permanent molar teeth only
h) Maximum of 2 procedures per arch per 24 months
i) Maximum of 1 per 5 year period per tooth
j) Maximum of 1 each quadrant per 12 months
k) Maximum of 1 each quadrant per 24 months
l) Maximum of 1 each tooth per 24 months
m) Subject to a yearly and lifetime maximum
n) Maximum of 1 each quadrant per 36 months
o) Replacement of existing only if in place for 24 months
p) Not in conjunction with TMJ
q) Benefits will be based on the benefit for the corresponding non-cosmetic restoration
r) Maximum 1 time per tooth
s) Maximum of 1 per lifetime
t) Only in conjunction with listed complex oral surgery procedures and subject to review
u) Limited to 2 oral evaluation procedures, in any combination (00120; 00140; 00150; 00160; 00180) per 12 month period
v) Limited to 1 bitewing x-ray procedure (00270; 00272; 00274) per 12 month period
w) Limited to dependent children under age 16
x) Subject to review
y) Limited to those age 25+
z) 6 months must have passed since initial placement
aa) Maximum of 1 per 7 year period
bb) Maximum of 1 per lifetime, per quadrant or arch
cc) Maximum of 1 per 5 year period
dd) Limited to patients age 16 and over
ee) X-Rays and pathology report required
ff) Limited to 1 x-ray procedure, (00210; 00277; 00330) per 5 year period