HumanaDental

State of Florida Employees

Humana®

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Four plans to choose from

Humana is pleased to offer you four dental plans to choose from this year. While some of the benefits are similar, others are distinct to each plan. Be sure to review the features in this book to make the right choice for your dental health and budget. Information on each plan is here.

Dental care is an important part of keeping your your good overall health.

Plans to choose from are:

- Two managed care plans, **Network Plus Prepaid** or **Select 15 Prepaid**
- A preferred provider dental plan, **Preferred Plus DPPO**
- An indemnity plan, **Schedule B**

Your cost in monthly premium

People First Benefit Plan Code	4004	4044	4054	4084
	Network Plus Prepaid	Select 15 Prepaid	Preferred Plus DPPO	Schedule B Indemnity
Employee only	$24.06	$12.64	$32.40	$14.74
Employee + Spouse	$47.42	$21.20	$59.94	$21.96
Employee + Child(ren)	$56.54	$23.00	$66.98	$23.30
Employee + Family	$72.22	$32.98	$97.24	$37.10

If you have questions, visit our website at **www.humanadental.com/custom/fl/** or call us between 8 a.m. and 6 p.m. Eastern time, Monday through Friday.

- Call 1-800-943-6880 for the Network Plus Prepaid and Preferred Plus DPPO plans
- Call 1-866-879-3630 for the Select 15 Prepaid and Schedule B plans

We will also have representatives available at all Department of Management Services (DMS) benefit fairs.

How do the plans work?

Network Plus and Select 15 Prepaid cover preventive care and other dental procedures as listed when you're treated by your selected primary care dentist. If your dentist decides you need more specialized treatment, you'll be referred to a participating specialist. With the Network Plus plan, the copayment listing in this brochure applies at both the participating general dentist and specialist. With the Select 15 plan, the participating specialist's fees will be discounted at 25 percent. General dentistry and specialty services are available only in areas where Humana has a participating general dentist and/or specialist.

Preferred Plus DPPO and **Schedule B** cover preventive care and other dental procedures as listed when you're treated by any dentist you choose. But with the Preferred Plus DPPO plan, a greater portion of your dental expenses will be covered for treatment performed by an in-network dentist who has agreed not to balance bill above the contracted fees. You'll be responsible for deductibles and there are benefit maximums.

Do I have to file a claim form?

Network Plus Prepaid and **Select 15 Prepaid:** No, all treatment will be coordinated by your primary care dentist. You're only responsible for the copayment listed on the benefit schedule.

Preferred Plus DPPO and **Schedule B:** Yes, you must submit a claim form to be reimbursed for your dental expenses. Most Preferred Plus DPPO dentists will agree to file the claim form on your behalf.

Submit claim forms to:
Humana
P.O. Box 14284
Lexington, KY 40512-4284

Predetermination

If covered dental expenses for a procedure are expected to be more than $200, it's recommended that you send a dental treatment plan before beginning treatment. You and/or your dentist will be notified of the benefits payable based on the dental treatment plan.

How do I know which dentist to see?

Network Plus Prepaid and **Select 15 Prepaid:** For participating dentist information, visit **www.humanadental.com/custom/fl/**. Once you enroll in your plan, you'll need to select a primary care dentist by registering at **www.mycompbenefits.com**.

Preferred Plus DPPO and **Schedule B:** You can choose any dentist. However, your costs may be lower when you choose an in-network dentist. For a listing of participating DPPO dentists, visit **www.humanadental.com/custom/fl/**.

Does everyone in my family need to use the same dentist?

No, each family member can have a different dentist. For instance, a spouse might choose to a dentist close to a workplace, a dependent college student living away from home (in Florida) might pick a dentist near school, and parents might choose to send their children to pediatric dentists who are more comfortable treating young children. Please note Network Plus limitations and exclusions regarding pediatric dentists.

What should I do if I have a question or concern?

Contact Humana between 8 a.m. and 6 p.m. Eastern time, Monday through Friday.

- Call 1-800-943-6880 for the Network Plus Prepaid and Preferred Plus DPPO plans
- Call 1-866-879-3630 for the Select 15 Prepaid and Schedule B plans

Humana's plans encourage preventive treatment, helping you to better oral health and keeping your costs down.

Network Plus Prepaid plan
People First Plan Code #4004

Selecting a dentist

For participating dentist information, you may visit our website at **www.humanadental.com/custom/fl/** or call our dedicated Customer Care number at 1-800-943-6880. Once you become enrolled in the Network Plus Prepaid plan, you will need to select a primary care dentist by registering at **www.mycompbenefits.com** or by calling our dedicated Customer Care number at 1-800-943-6880.

The schedule of benefits below represents your copayments for treatment provided by participating general dentists and specialists. Please note limitations and exclusions apply. Refer to the Network Plus Prepaid Plan Limitations & Exclusions section for more details.

Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age	$0
D0150	Comprehensive oral evaluation	$0
D0160	Detailed & extensive oral evaluation – problem focused	$0
D0170	Re-evaluation - limited, problem focused	$0
D0180	Comprehensive periodontal evaluation	$0
D0210	Intraoral - complete series	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings - three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture & sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross exam, prep & report	$50
D0473	Accession of tissue, gross and microscopic exam, prep & report	$50
D0474	Accession of tissue, gross and microscopic exam, including assesment of surgical margins, prep & report	$50
D1110	Prophylaxis - adult	$0
D1110	Additional prophylaxis - adult	$25
D1120	Prophylaxis - child	$0
D1120	Additional prophylaxis - child	$20
D1203	Topical fluoride - child	$0
D1204	Topical fluoride - adult	$0
D1206	Topical fluoride varnish	$0
D1310	Nutritional counseling	$0
D1320	Tobacco counseling	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Recementation of space maintainer	$0
D2140	Amalgam - one surface, primary or permanent	$6
D2150	Amalgam - two surfaces, primary or permanent	$8
D2160	Amalgam - three surfaces, primary or permanent	$9
D2161	Amalgam - four or more surfaces, primary or permanent	$11
D2330	Resin-based composite - one surface, anterior	$8
D2331	Resin-based composite - two surfaces, anterior	$10
D2332	Resin-based composite - three surfaces, anterior	$13
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	$15
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite - one surface, posterior	$6
D2392	Resin-based composite - two surfaces, posterior	$8
D2393	Resin-based composite - three surfaces, posterior	$9
D2394	Resin-based composite - four or more surfaces, posterior	$11
D2510	Inlay - metallic - one surface	$105
D2520	Inlay - metallic - two surfaces	$115
D2530	Inlay - metallic - three or more surfaces	$125
D2542	Onlay - metallic - two surfaces	$175
D2543	Onlay - metallic - three surfaces	$185
D2544	Onlay - metallic - four or more surfaces	$195
D2610	Inlay - porcelain/ceramic - one surface	$202
D2620	Inlay - porcelain/ceramic - two surfaces	$214
D2630	Inlay - porcelain/ceramic - three or more surfaces	$227
D2642	Onlay - porcelain/ceramic - two surfaces	$221
D2643	Onlay - porcelain/ceramic - three surfaces	$238

Network Plus Prepaid plan
People First Plan Code #4004

Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D2644	Onlay - porcelain/ceramic - four or more surfaces	$253
D2650	Inlay - resin-based composite - one surface	$166
D2651	Inlay - resin-based composite - two surfaces	$198
D2652	Inlay - resin-based composite - three surfaces	$208
D2662	Onlay - resin-based composite - two surfaces	$180
D2663	Onlay - resin-based composite - three surfaces	$212
D2664	Onlay - resin-based composite - four or more surfaces	$228
D2710	Crown - resin-based composite (indirect)	$228
D2712	Crown - 3/4 resin-based composite (indirect)	$228
D2720	Crown - resin with high noble metal	$150
D2721	Crown - resin with predominantly base metal	$150
D2722	Crown - resin with noble metal	$150
D2740	Crown - porcelain/ceramic substrate	$280
D2750	Crown - porcelain fused to high noble metal	$150
D2751	Crown - porcelain fused to predominantly base metal	$150
D2752	Crown - porcelain fused to noble metal	$150
D2780	Crown - 3/4 cast high noble metal	$150
D2781	Crown - 3/4 cast predominantly base metal	$150
D2782	Crown - 3/4 cast noble metal	$150
D2783	Crown - 3/4 porcelain/ceramic	$280
D2790	Crown - full cast high noble metal	$150
D2791	Crown - full cast predominantly base metal	$150
D2792	Crown - full cast noble metal	$150
D2794	Crown - titanium	$150
D2799	Provisional crown	$150
D2910	Recement inlay, onlay	$6
D2915	Recement cast or prefabricated post and core	$6
D2920	Recement crown	$6
D2930	Prefabricated stainless steel crown - primary tooth	$63
D2931	Prefabricated stainless steel crown - permanent tooth	$72
D2932	Prefabricated resin crown	$78
D2933	Prefabricated stainless steel crown with resin window	$88
D2940	Sedative filling	$6
D2950	Core buildup, including any pins	$59
D2951	Pin retention - per tooth, in addition to restoration	$13
D2952	Cast post and core in addition to crown	$86
D2953	Cast post and core each additional - same tooth	$86
D2954	Prefabricated post and core in addition to crown	$81
D2955	Post removal	$50
D2957	Each additional prefabricated post - same tooth	$81
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300
D2962	Labial veneer (porcelain laminate) - laboratory	$350
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair, by report	$50
D3110	Pulp cap - direct	$4
D3120	Pulp cap - indirect	$3
D3220	Therapeutic pulpotomy	$10
D3221	Pulpal debridement, primary and permanent teeth	$15
D3230	Pulpal therapy - anterior, primary tooth	$15
D3240	Pulpal therapy - posterior, primary tooth	$15
D3310	Root canal therapy - anterior	$41
D3320	Root canal therapy - bicuspid	$50
D3330	Root canal therapy - molar	$64
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$105
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy - anterior	$55
D3347	Retreatment of previous root canal therapy - bicuspid	$65
D3348	Retreatment of previous root canal therapy - molar	$78
D3351	Apexification/recalcification - initial visit	$65
D3352	Apexification/recalcification - interim visit	$65
D3353	Apexification/recalcification - final visit	$65
D3410	Apicoectomy/periradicular surgery - anterior	$47
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$51
D3425	Apicoectomy/periradicular surgery - molar (first root)	$58
D3426	Apicoectomy/periradicular surgery - each additional root	$19
D3430	Retrograde filling - per root	$14
D3450	Root amputation - per root	$29
D3910	Surgical procedure for isolation of tooth with rubber dam	$20
D3920	Hemisection, not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	$39

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Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth per quadrant	$10
D4240	Gingival flap procedure - four or more contiguous teeth per quadrant	$150
D4241	Gingival flap procedure - one to three contiguous teeth per quadrant	$115
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$140
D4260	Osseous surgery, four or more contiguous teeth per quadrant	$75
D4261	Osseous surgery, one to three contiguous teeth per quadrant	$75
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$60
D4267	Guided tissue regeneration - nonresorbable barrier, per site	$64
D4270	Pedicle soft tissue graft procedure	$55
D4271	Free soft tissue graft procedure	$57
D4273	Subepithelial connective tissue graft, per tooth	$75
D4274	Distal or proximal wedge procedure	$70
D4275	Soft tissue allograft	$265
D4320	Provisional splinting - intracoronal	$95
D4321	Provisional splinting - extracoronal	$85
D4341	Periodontal scaling and root planing - four or more contiguous teeth per quadrant	$14
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$14
D4355	Full mouth debridement	$9
D4381	Localized delivery of antimicrobial agents, per tooth	$35
D4910	Periodontal maintenance	$9
D4999	Unspecified periodontal procedure, by report	$0
D5110	Complete denture - maxillary	$320
D5120	Complete denture - mandibular	$320
D5130	Immediate denture - maxillary	$349
D5140	Immediate denture - mandibular	$349
D5211	Maxillary partial denture - resin base	$292
D5212	Mandibular partial denture - resin base	$292
D5213	Maxillary partial denture - cast metal framework with resin	$354
D5214	Mandibular partial denture - cast metal framework with resin	$354
D5225	Maxillary partial denture - flexible base	$365
D5226	Mandibular part denture - flexible base	$365
D5281	Removable unilateral partial denture - one piece cast metal	$250
D5410	Adjust complete denture - maxillary	$18
D5411	Adjust complete denture - mandibular	$18
D5421	Adjust partial denture - maxillary	$18
D5422	Adjust partial denture - mandibular	$18
D5510	Repair broken complete denture base	$9
D5520	Replace missing or broken teeth - complete denture (each tooth)	$7
D5610	Repair resin denture base	$10
D5620	Repair cast framework	$10
D5630	Repair or replace broken clasp	$13
D5640	Replace broken teeth - per tooth	$8
D5650	Add tooth to existing partial denture	$11
D5660	Add clasp to existing partial denture	$13
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$31
D5711	Rebase complete mandibular denture	$31
D5720	Rebase maxillary partial denture	$31
D5721	Rebase mandibular partial denture	$31
D5730	Reline complete maxillary denture (chairside)	$18
D5731	Reline complete mandibular denture (chairside)	$18
D5740	Reline maxillary partial denture (chairside)	$18
D5741	Reline mandibular partial denture (chairside)	$18
D5750	Reline complete maxillary denture (laboratory)	$24
D5751	Reline complete mandibular denture (laboratory)	$24
D5760	Reline maxillary partial denture (laboratory)	$24
D5761	Reline mandibular partial denture (laboratory)	$24
D5810	Interim complete denture (maxillary)	$225
D5811	Interim complete denture (mandibular)	$225
D5820	Interim partial denture (maxillary)	$225
D5821	Interim partial denture (mandibular)	$225
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$180
D6210	Pontic - cast high noble metal	$150
D6211	Pontic - cast predominantly base metal	$150
D6212	Pontic - cast noble metal	$150
D6214	Pontic - titanium	$150
D6240	Pontic - porcelain fused to high noble metal	$150
D6241	Pontic - porcelain fused to predominantly base metal	$150
D6242	Pontic - porcelain fused to noble metal	$150

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Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D6245	Pontic - porcelain/ceramic	$280
D6250	Pontic - resin with high noble metal	$150
D6251	Pontic - resin with predominantly base metal	$150
D6252	Pontic - resin with noble metal	$150
D6253	Provisional pontic	$75
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$150
D6600	Inlay - porcelain/ceramic, two surfaces	$214
D6601	Inlay - porcelain/ceramic, three or more surfaces	$227
D6602	Inlay - cast high noble metal, two surfaces	$115
D6603	Inlay - cast high noble metal, three or more surfaces	$125
D6604	Inlay - cast predominantly base metal, two surfaces	$115
D6605	Inlay - cast predominantly base metal, three or more surfaces	$125
D6606	Inlay - cast noble metal, two surfaces	$115
D6607	Inlay - cast noble metal, three or more surfaces	$125
D6608	Onlay - porcelain/ceramic, two surfaces	$221
D6609	Onlay - porcelain/ceramic, three or more surfaces	$238
D6610	Onlay - cast high noble metal, two surfaces	$175
D6611	Onlay - cast high noble metal, three or more surfaces	$185
D6612	Onlay - cast predominantly base metal two surfaces	$175
D6613	Onlay - cast predominantly base metal three or more surfaces	$185
D6614	Onlay - cast noble metal, two surfaces	$175
D6615	Onlay - cast noble metal, three or more surfaces	$185
D6710	Crown - indirect resin based composite	$228
D6720	Crown - resin with high noble metal	$150
D6721	Crown - resin with predominantly base metal	$150
D6722	Crown - resin with noble metal	$150
D6740	Crown - porcelain/ceramic	$280
D6750	Crown - porcelain fused to high noble metal	$150
D6751	Crown - porcelain fused to predominantly base metal	$150
D6752	Crown - porcelain fused to noble metal	$150
D6780	Crown - 3/4 cast high noble metal	$150
D6781	Crown - 3/4 cast predominantly base metal	$150
D6782	Crown - 3/4 cast noble metal	$150
D6783	Crown - 3/4 porcelain/ceramic	$150
D6790	Crown - full cast high noble metal	$150
D6791	Crown - full cast predominantly base metal	$150
D6792	Crown - full cast noble metal	$150
D6794	Crown - titanium	$150
D6930	Recement fixed partial denture	$8
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Cast post and core in addition to fixed partial denture retainer	$89
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$81
D6973	Core build up for retainer, including any pins	$59
D6976	Each additional cast post - same tooth	$89
D6977	Each additional prefabricated post - same tooth	$81
D6980	Fixed partial denture repair, by report	$45
D7111	Extraction, coronal remnants - deciduous tooth	$8
D7140	Extraction, erupted tooth or exposed root	$8
D7210	Surgical removal of erupted tooth	$14
D7220	Removal of impacted tooth - soft tissue	$17
D7230	Removal of impacted tooth - partially bony	$23
D7240	Removal of impacted tooth - completely bony	$27
D7241	Removal of impacted tooth - completely bony with surgical complications	$34
D7250	Surgical removal of residual tooth roots	$15
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Surgical access of an unerupted tooth	$33
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of devise to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue - hard	$150
D7286	Biopsy of oral tissue - soft	$75
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions - four or more teeth per quadrant	$16
D7311	Alveoloplasty in conjunction with extractions - one to three teeth per quadrant	$16
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth per quadrant	$72
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth per quadrant	$72
D7471	Removal of lateral exostosis	$62
D7472	Removal of torus palatinus	$72
D7473	Removal of torus mandibularis	$72
D7485	Surgical reduction of osseous tuberosity	$72
D7510	Incision and drainage of abscess - intraoral soft tissue	$16
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated	$16

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Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D7520	Incision and drainage of abscess - extraoral soft tissue	$35
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated	$35
D7910	Suture of recent small wounds up to 5 cm	$35
D7960	Frenulectomy - separate procedure	$34
D7963	Frenuloplasty	$34
D7970	Excision of hyperplastic tissue - per arch	$35
D7971	Excision of pericoronal gingiva	$35
D8010	Limited orthodontic treatment - primary dentition	$725
D8020	Limited orthodontic treatment - transitional dentition	$725
D8030	Limited orthodontic treatment - adolescent dentition	$725
D8040	Limited orthodontic treatment - adult dentition	$725
D8050	Interceptive orthodontic treatment - primary dentition	$910
D8060	Interceptive orthodontic treatment - transitional dentition	$970
D8070	Comprehensive orthodontic treatment - transitional dentition	$1,580
D8080	Comprehensive orthodontic treatment - adolescent dentition	$1,580
D8090	Comprehensive orthodontic treatment - adult dentition	$1,580
D8660	Pre-orthodontic treatment visit	$80
D8680	Orthodontic retention	$250
D9110	Palliative treatment of dental pain - minor procedure	$6
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 min.	$23
D9221	Deep sedation/general anesthesia - each additional 15 min	$10
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia - first 30 min.	$23
D9242	Intravenous conscious sedation/analgesia - each additional 15 min	$10
D9248	Non-intravenous conscious sedation	$10
D9310	Consultation	$0
D9430	Office visit for observation - no other services performed.	$0
D9440	Office visit - after regularly scheduled hours	$40
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic drug injection, single administration	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$120
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$150
D9972	External bleaching - per arch	$125

Network Plus Prepaid plan
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Limitations & Exclusions

Limitations:

- Unlisted services are at the Participating Dentist's usual fee less 25 percent.
- Services performed for cosmetic reasons are at the Participating Dentist's usual fee less 25 percent.
- Oral evaluations limited to once every six months.
- Bitewing radiographs limited to once every six months.
- Panoramic or full-mouth series radiographs limited to once every three years or more often, if medically necessary.
- Prophylaxis limited to twice per year. Additional prophylaxis available when medically necessary.
- Sealants limited to one per tooth every three years on permanent first molars up to age 14.
- Scaling and root planing limited to once every 12 months.
- Full mouth debridement limited to once every five years.
- Periodontal maintenance limited to once every six months.
- Services provided by Participating General Dentists only: Cost of noble, high noble or titanium metal is $150 additional.
- Cases involving seven or more units of crowns and/or fixed bridge units include an additional charge of $125 per unit.
- Relines limited to one every 12 months.
- Removal of asymptomatic third molars isn't a covered benefit unless pathology (disease) exists. Asymptomatic third molars may be removed at the Participating Dentist's usual fee less 25 percent.
- Benefits at the listed copayments are available at the Participating General Dentist or Participating Specialist, except for Pediatric Dentistry older than 6. Benefits at the Participating Pediatric Dentist for children older than 6 are available at the Participating Pediatric Dentist's usual fee less 25 percent.
- General anesthesia, IV sedation, and nitrous oxide are covered only when medically necessary and provided in conjunction with complex oral and periodontal surgical procedures.
- Comprehensive orthodontic treatment at the listed copayment is limited to one 24-month course of treatment.

Exclusions:

- No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as specified in the Certificate.
- Whenever any contributions or copayments are delinquent, Member will not be entitled to receive Benefits, transfer dental facilities or enjoy any of the other privileges of a Member in good standing.
- Company does not provide coverage for the following:
  - Cost of hospitalization and/or any pharmaceuticals, drugs or medications unless specifically listed on the Schedule of Benefits.
  - Services that in the opinion of the Participating General Dentist, Participating Specialist or Company are (a) not medically necessary; (b) not appropriate for the given condition or not customarily used for dental care; (c) do not have uniform professional endorsement or do not meet the standards set by the American Dental Association; (d) experimental or investigational in nature; (e) for which the Member has no legal obligation to pay; or (f) for which a charge would have been made in the absence of insurance
  - Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
  - Any service or procedure that the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
  - Any dental treatment started prior to the Member's effective date for eligibility of Benefits.
  - Services for injuries and conditions that are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.
  - Treatment for cysts, neoplasms, and malignancies, unless specifically listed on the Schedule of Benefits.
  - Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
  - Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the termporomandibular joints or their structures.
  - Procedures performed by a dentist who is a member of Your immediate family.
  - Charges for treatment rendered in (a) a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or (b) by an employee of any Member.

Preferred Plus DPPO plan
People First Plan Code #4054

Schedule of benefits

	In-network	Out-of-network
Calendar year deductible		
Waived for Type I – diagnostic and preventive services	$25 individual $50 family	$50 individual $100 family
Calendar year maximum		
Type I, II, III The ***combined*** calendar year maximum for the in- and out-of-network benefits is $1,200 per covered person.	$1,200 per covered person	$1,200 per covered person
Waiting period		
Type I, II, III Type IV – Orthodontic	None Prior carrier credit (12-month wait for new enrollees)	None Not covered
Type I – Diagnostic & Preventive Services • Oral exam (one per 6 months) • Prophylaxis (cleaning,one per 6 months) • Topical fluoride (children under 16, once per 12 months) • Sealants (one per 3-year period; limited to children under 16 for non-carious molars) • X-rays (limitations apply)	100%*	80%**
Type II – Basic Services • Fillings (silver and white) • Extractions • Periodontics (gum treatment) • Endodontics (root canal)	80%*	50%**
Type III – Major Services • Crowns • Inlays and onlays • Fixed bridgework • Full and partial dentures • Emergency palliative treatment	50%*	30%**
Type IV – Orthodontic Services (Adult and child)	50%* $1,500 lifetime maximum benefit	Not covered

* We have negotiated fees with participating DPPO dentists. Benefits are covered at the listed percentage of the negotiated fees.

** Coverage based on usual, customary and reasonable fees.

Please note limitations and exclusions apply. Refer to the Preferred Plus DPPO Plan, Limitations & Exclusions Section for more details.

Preferred Plus DPPO plan
People First Plan Code #4054

Limitations & Exclusions

Major restorative limitations:

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

- A denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy; however, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
- The replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
- The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
- The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
- The replacement of teeth up to the normal complement of 32.

Exclusions:

Benefits will not be paid for:

- Procedures that are not included in the Schedule of Benefits; that are not medically necessary; that do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
- Any procedure, service, or supply that may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling;
- Appliances, inlays, cast restorations, or other laboratory prepared restorations used primarily for the purpose of splinting;
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
- Pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g., waterpik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of Your immediate family;
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
- Charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
- Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
- Charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside of the United States are limited to a maximum of $100 (U.S. dollars) per year;
- The care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
- Treatment for cosmetic purposes – facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- Any services or supplies that do not meet the standards set by the American Dental Association or that are not reasonably necessary, or customarily used, for dental care;
- Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- An injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
- Charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, Company will determine the amount. Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors.

Select 15 Prepaid plan
People First Plan Code #4044

Selecting a dentist

For participating dentist information, you may visit our website at **www.humanadental.com/custom/fl/** or call our dedicated Customer Care number at 1-866-879-3630. Once you become enrolled in the Select 15 plan, you will need to select a primary care dentist by registering at **www.mycompbenefits.com** or by calling our dedicated Customer Care number at 1-866-879-3630.

Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
APPOINTMENTS		
D9430	Office visit (normal hours)	$5
D9440	Office visit after regularly scheduled hours	$35
D9999	Emergency office visit during regularly scheduled hours, by report	$20
D9999	Broken appointments (without 24 hr notice, per 15 min). Maximum $40 per broken appointment. No charge will be made due to emergencies.	$10
DIAGNOSTIC		
D0120	Periodic oral evaluation	NO CHARGE
D0140/D0150/D0160	Oral evaluation	NO CHARGE
D0180	Comprehensive periodontal evaluation	NO CHARGE
D0470	Diagnostic casts (study models)	NO CHARGE
D0999	Diagnosis and treatment plan presentation, by report	NO CHARGE
D9310	Consultation (second opinion) as provided by participating dentist.	$10
D0460	Pulp vitality tests.	NO CHARGE
RADIOGRAPHS (X-rays)		
D0210	Intraoral - complete series, including bitewings	NO CHARGE
D0220	Intraoral - periapical - first film	NO CHARGE
D0230	Intraoral - periapical - each additional film	NO CHARGE
D0270	Bitewings - single film	NO CHARGE
D0272	Bitewings - two fims	NO CHARGE
D0274	Bitewings - four films.	NO CHARGE
D0330	Panoramic	NO CHARGE
PREVENTIVE		
D1110/D1120	Prophylaxis (routine, once every 6 months)	NO CHARGE
D1110/D1120	Additional prophylaxis	$15
D1201	Topical application of fluoride (including prophylaxis, up to 16 years of age).	NO CHARGE
D1203	Topical application of fluoride (prophylaxis not included up to 16 years of age)	NO CHARGE
D1351	Sealant - per tooth	$7
D1330	Oral hygiene instruction	NO CHARGE

ADA CODE	PROCEDURE	MEMBER PAYS
SPACE MAINTAINERS		
D1510	Fixed, unilateral.	$45*
D1515	Fixed, bilateral	$45*
D1520	Removable, unilateral	$85.00*
D1525	Removable, bilateral	$85.00*
D1550	Recementation of space maintainer	$10
RESTORATIVE (fillings)		
D2999	Sedative base (under fillings), by report.	NO CHARGE
Amalgam (Silver)		
D2140	Amalgam - one surface, primary or permanent	NO CHARGE
D2150	Amalgam - two surface, primary or permanent	NO CHARGE
D2160	Amalgam - three surface, primary or permanent	NO CHARGE
D2161	Amalgam - four or more surfaces, primary or permanent.	NO CHARGE
Resin restoration (including acid etching, liners and bases)		
D2330	Anterior one surface	$30
D2331	Anterior two surfaces	$37
D2332	Anterior three surfaces	$45
D2510	Inlay - metallic - one surface.	$85
D2520	Inlay - metallic - two surfaces.	$95
D2530	Inlay - metallic - three or more surfaces.	$120
D2940	Sedative filling.	$15
CROWN & BRIDGE		
D2930	Prefabricated stainless steel - primary tooth	$45
D2790/D2791/D2792/D6790/D6791/D6792	Full cast crown	$220
D2750/D2751/D2752/D6750/D6751/D6752	Porcelain fused to metal crown.	$240
D2781	3/4 cast crown, predominantly base metal	$220
Pontics		
D6210/D6211/D6212	Full cast pontic.	$220
D6240/D6241/D6242	Porcelain fused to metal pontic	$240
D2950	Core build up, including any pins.	$40
D2951	Pin retention - per tooth	$12
D2952	Cast post and core	$90
D2954	Prefabricated post and core.	$75

Select 15 Prepaid plan
People First Plan Code #4044

Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D2910/D2920/D6930	Recement inlay/onlay/crown/bridge (per unit)	$10
ENDODONTICS		
D3220	Therapeutic pulpotomy	$30
Root Canals		
D3310	Anterior	$100
D3320	Bicuspid	$190
D3330	Molar	$240
D3410	Apicoectomy (anterior only)	$95
PERIODONTICS (gum treatment)		
D4210	Gingivectomy/gingivoplasty - per quadrant	$120
D4211	Gingivectomy/gingivoplasty - per tooth	$36
D4341	Periodontal scaling and root planing - per quadrant	$45
D4342	Scaling and root planing (one to three teeth per quadrant)	$45
D4355	Full mouth debridement	$35
D4381	Localized delivery of chemotherapeutic agents (2 teeth)	$45
D4910	Periodontal maintenance procedures	$45
PROSTHODONTICS		
Standard complete dentures (includes adjustments within 30 days)		
D5110	Complete maxillary (upper)	$260
D5120	Complete mandibular (lower)	$260
D5130	Immediate maxillary (upper)	$280
D5140	Immediate mandibular (lower)	$280
Partial dentures (includes adjustments within 30 days)		
D5211/D5212	Maxillary/mandibular partial - resin base (with 2 clasps)	$280
D5213/D5214	Maxillary/mandibular partial - cast metal with resin base (with 2 clasps)	$350
D5410/D5411	Adjust complete - maxillary/mandibular	$15
D5421/D5422	Adjust partial denture - maxillary/mandibular	$15
D5999	Additional clasps, by report	$30
REPAIRS TO PROSTHETICS		
D5510/D5610	Repair broken resin denture base	$15*
D5520/D5640	Replace missing or broken teeth (each tooth)	$10*
D5520/D5640	Each additional tooth	$10*
D5630	Repair or replace broken clasp	$15*
D5650	Add tooth to existing partial denture	$30*
D5850/D5851	Tissue conditioning, maxillary/mandibular	$25
D5730/D5731/D5740/D5741	Relining (chairside)	$45
D5750/D5751/D5760/D5761	Relining (laboratory)	$35*
EXTRACTIONS/ORAL SURGERY		
D7111	Extraction, coronal remnants, primary tooth	NO CHARGE
D7140	Extraction, erupted tooth or exposed root (evaluation and/or forceps removal)	NO CHARGE
D7210	Surgical extraction of erupted tooth	$25
D7220	Soft tissue impaction	$40
D7230	Partially bony impaction	$60
D7240	Completely bony impaction	$75
D7250	Surgical removal of residual tooth roots	$25
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$20
D7311	Alveoloplasty in conjuction with extractions (one to three teeth or tooth spaces, per quadrant)	$20
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$50
D7321	Alveoloplasty not in conjunction with extractions (one to three teeth or tooth spaces, per quadrant)	$50
ANESTHESIA		
D9215	Local anesthesia	NO CHARGE
D9230	Analgesia (nitrous oxide - per 15 minutes)	$15
ADJUNCTIVE SERVICES		
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$150
ORTHODONTICS		

Benefits for orthodontics for adults and children are available from Participating Orthodontists at their usual fee less 25 percent.

* Plus laboratory fees when applicable.

Note: When crown and/or bridgework exceeds six consecutive units, the patient may be charged an additional $25 per unit.

THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS AND SEMI PRECIOUS METAL.

All procedures listed might not be performed by the Participating General Dentist you select. The copayments shown apply to those Company Participating General Dentists who do perform those services. Therefore, you are encouraged to discuss availability of the scheduled services with your Participating General Dentist. Procedures not listed on the schedule of benefits, that are performed by the Participating General Dentist, will be charged at that Participating General Dentist's usual and customary fee less 25 percent.

Select 15 Prepaid plan
People First Plan Code #4044

SPECIALISTS

Should you need a specialist (i.e., Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating specialist from our directory. Upon identification of yourself as a Company member, you will receive a 25 percent reduction from usual and customary fees for services performed. Specialist services are available only in areas where the dental plan has a Participating Specialist.

Limitations & Exclusions

- No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of the Certificate.
- Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
- Company does not provide coverage for the following services:

  a) Cost of hospitalization and pharmaceuticals, drugs or medications.

  b) Services that in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.

  c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.

  d) Any service or procedure that the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.

  e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.

  f) Services for injuries and conditions that are paid or payable under Workers' Compensation or Employers' Liability laws.

  g) Treatment for cysts, neoplasms, and malignancies.

  h) General anesthesia.

Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits:

Calendar year deductible	
Waived for Type I – preventive dental services	$50 individual $150 family (3 per family)
Calendar year maximum	
Type I, II, III	$1,000 per covered person
Waiting period	
Type I, II, III	None

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
TYPE I - PREVENTIVE DENTAL SERVICES		
D0120	Periodic oral examination[1]	$11.70
D0140	Limited oral evaluation - (problem focused)[1]	$15.30
D0150	Comprehensive oral evaluation - new or established patient[1]	$15.30
D0180	Comprehensive periodontal evaluation - new or established patient[1]	$15.30
[1] Covered twice per 12 consecutive months		
D0210	Intraoral - complete series, inc. bitewings (Covered once per 3 years)	$30.60
D0220	Intraoral - periapical - first film	$6.30
D0230	Intraoral - periapical - each additional film	$6.30
D0240	Intraoral - occlusal film	$8.10
D0250	Extraoral - first film	$10.80
D0260	Extraoral - each additional	$9.00
D0270	Bitewings - single film (Covered twice per 12 consecutive months)	$9.90
D0272	Bitewings - two films (Covered twice per 12 consecutive months)	$12.60
D0274	Bitewings - four films (Covered twice per 12 consecutive months)	$16.20
D0290	Posterior - anterior or lateral skull and facial bone survey film	$21.60
D0330	Panoramic film (Covered once per 3-year period)	$23.40
D0415	Bacteriologic studies for determination of pathologic agents	$18.00
D1110	Prophylaxis - adult (Covered twice per 12 consecutive months)	$18.90
D1120	Prophylaxis - child (Covered twice per 12 consecutive months)	$18.00
D1201	Topical application of fluoride (prophylaxis included) - child (Covered twice per 12 consecutive months for a dependent child under 16)	$21.60
D1203	Topical application of fluoride (prophylaxis not included) - child (Covered twice per 12 consecutive months for a dependent child under 16)	$15.30
D1351	Sealant - per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	$6.30
D1510	Space maintainer - fixed - unilateral	$80.10
D1515	Space maintainer - fixed - bilateral	$108.00
D1520	Space maintainer - removable - unilateral	$100.80
D1525	Space maintainer - removable - bilateral	$109.80
D1550	Recementation of space maintainer	$13.50
D7285	Biopsy of oral tissue - hard	$45.00
D7286	Biopsy of oral tissue - soft	$30.60
D9110	Palliative treatment (Covered as seperate procedure if no other service, except X-rays, is rendered during the visit)	$14.40
TYPE II - BASIC DENTAL SERVICES		
D2140	Amalgam - one surface, primary or permanent[2]	$11.70
D2150	Amalgam - two surfaces, primary or permanent[2]	$18.00
D2160	Amalgam - three surfaces, primary or permanent[2]	$22.50
D2161	Amalgam - four or more surfaces, primary or permanent[2]	$28.80
[2] Multiple restorations on one surface will be covered as a single filling		

Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2330	Resin-based composite- one surface, anterior[3]	$15.30
D2331	Resin-based composite - two surfaces, anterior[3]	$22.50
D2332	Resin-based composite - three surfaces, anterior[3]	$30.60
D2335	Resin-based composite - four or more surfaces or involving incisal angle[3]	$28.80
D2391	Resin-based composite - one surface, posterior[3]	$11.70
D2392	Resin-based composite - two surfaces, posterior[3]	$18.80
D2393	Resin-based composite - three surfaces, posterior[3]	$22.50
D2394	Resin-based composite - four or more surfaces, posterior[3]	$22.50

[3] *Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.*

D2910	Recement inlay	$11.70
D2920	Recement crown	$11.70
D2940	Sedative filling (Covered as seperate procedure if no other service, except X-rays, rendered during the visit)	$12.60
D2950	Core buildup, including any pins	$36.00
D2951	Pin retention - per tooth - in addition to restoration	$17.10
D3220	Therapeutic pulpotomy, excluding final restoration	$20.70
D3310	Root canal therapy - anterior, excluding final restoration	$162.00
D3320	Root canal therapy - bicuspid, excluding final restoration	$198.00
D3330	Root canal therapy - molar, excluding final restoration	$243.00
D3351	Apexification/recalcification - initial visit	$45.90
D3352	Apexification/recalcification - interim medication	$45.90
D3353	Apexification/recalcification - final visit	$45.90
D3410	Apicoectomy/periradicular surgery - anterior	$71.10
D3421	Apicoectomy/periradicular surgery - bicuspid	$71.10
D3425	Apicoectomy/periradicular surgery - molar	$71.10
D3430	Retrograde filling - per tooth	$26.10
D3450	Root amputation - per root	$38.70
D3920	Hemisection (including root removal), not including root canal therapy	$38.70
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth, per quadrant[4]	$51.30
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant[4]	$13.50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth, per quadrant[4]	$57.60
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant[4]	$57.60

[4] *Only one of these procedures is covered per area of the mouth.*

D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth, per quadrant	$95.40
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$95.40
D4270	Pedicle soft tissue graft procedure	$57.60
D4271	Free soft tissue graft procedure (including donor site surgery)	$63.90
D4320	Provisional splinting - intracoronal	$18.00
D4321	Provisional splinting - extracoronal	$18.00
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth, per quadrant[5]	$14.40
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant[5]	$14.40
D4355	Full mouth debridement to enable comprehensive eval. and diagnosis[5]	$30.60
D4910	Periodontal maintenance[5]	$19.80

[5] *Covered twice per area of the mouth per 12 consecutive months*

D5510	Repair broken complete denture base[6]	$26.10

Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5520	Replace missing or broken teeth - complete denture[6]	$26.10
D5610	Repair resin denture base[6]	$26.10
D5620	Repair cast framework[6]	$26.10
D5630	Repair or replace broken clasp[6]	$30.60
D5640	Replace broken teeth - per tooth[6]	$18.90
D5650	Add tooth to existing partial denture[6]	$36.00
D5660	Add clasp to existing partial denture[6]	$38.70
D5710	Rebase complete maxillary denture[6]	$76.50
D5711	Rebase complete mandibular denture[6]	$76.50
D5720	Rebase maxillary partial denture[6]	$76.50
D5721	Rebase mandibular partial denture[6]	$76.50
D6930	Recement fixed partial denture.	$16.20
D7111	Coronal remnants, deciduous tooth	$14.40
D7140	Extraction, erupted tooth or exposed root (elev. and/or forceps removal)	$14.40
D7210	Surgical removal of erupted tooth	$26.10
D7220	Removal of impacted tooth - soft tissue	$36.00
D7230	Removal of impacted tooth - partially bony	$45.90
D7240	Removal of impacted tooth - completely bony	$61.20
D7250	Surgical removal of residual tooth roots	$28.80
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$47.70
D7272	Tooth transplantation	$51.30
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$21.60
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$21.60
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$25.20
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25.20
D7340	Vestibuloplasty - ridge extension (second epithelialization)	$38.70
D7350	Vestibuloplasty - ridge extension (incl. tissue procedures)	$76.50
D7510	Incision and drainage of abscess - intraoral soft tissue.	$22.50
D7520	Incision and drainage of abscess - extraoral soft tissue.	$34.20
D7960	Frenulectomy - separate procedure	$33.30
D7970	Excision of hyperplastic tissue - per arch	$38.70
D9220	Deep sedation/general anesthesia - first 30 minutes[7]	$30.60
D9610	Therapeutic drug injection	$11.70
D9951	Occlusal adjustment - limited[8]	$14.40
D9952	Occlusal adjustment - Complete[8]	$36.90

[6] *Covered only if repairs/adjustments more than 1 year after the initial insertion*

[7] *Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company.*

[8] *Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment.*

TYPE III - MAJOR DENTAL SERVICES

D0470	Diagnostic casts	$15.30
D2510	Inlay - metallic - one surface	$57.60
D2520	Inlay - metallic - two surfaces	$79.20
D2530	Inlay - metallic - three or more surfaces	$85.50
D2610	Inlay - porcelain/ceramic - one surface	$26.10
D2620	Inlay - porcelain/ceramic - two surfaces	$52.20
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$78.30
D2710	Crown resin (laboratory) (Single restoration only)	$51.30
D2720	Crown - resin high noble metal (Single restoration only)	$98.10
D2721	Crown - resin predominantly base metal (Single restoration only)	$85.50
D2722	Crown - resin with noble metal (Single restoration only)	$89.10
D2740	Crown - porcelain/ceramic substrate (Single restoration only)	$95.40
D2750	Crown - porcelain fused to high noble metal (Single restoration only)	$180.00
D2751	Crown - porcelain fused to predominantly base metal (Single restoration only).	$91.80

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Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2752	Crown - porcelain fused to noble metal (Single restoration only)	$95.40
D2790	Crown - full cast high noble metal (Single restoration only)	$175.50
D2791	Crown - full cast predominantly base metal (Single restoration only)	$82.80
D2792	Crown - full cast noble metal (Single restoration only)	$89.10
D2930	Prefabricated stainless steel crown - primary tooth (Single restoration only)	$21.60
D2931	Prefabricated stainless steel crown - permanent (Single restoration only)	$21.60
D2952	Cast post and core in addition to crown (Single restoration only)	$36.00
D2954	Prefabricated post and core in addition to crown (Single restoration only)	$26.10
D5110	Complete upper denture	$129.60
D5120	Complete lower denture	$129.60
D5130	Immediate upper denture	$135.90
D5140	Immediate lower denture	$135.90
D5211	Upper partial denture - resin base	$79.20
D5212	Lower partial denture - resin base	$79.20
D5213	Upper partial denture - cast metal base with resin saddles	$145.80
D5214	Lower partial denture - cast metal base with resin saddles	$134.10
D5281	Removable unilateral partial denture - one piece cast metal	$28.80
D5410	Adjust complete denture - upper[9]	$8.10
D5411	Adjust complete denture - lower[9]	$8.10
D5421	Adjust partial denture - upper[9]	$8.10
D5422	Adjust partial denture - lower[9]	$8.10
D5730	Reline complete upper denture (chairside)[10]	$32.40

[9] Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture

D5731	Reline complete lower denture (chairside) [10]	$32.40
D5740	Reline upper partial denture (chairside)[10]	$26.10
D5741	Reline lower partial denture (chairside)[10]	$26.10
D5750	Reline complete upper denture (laboratory) [10]	$47.70
D5751	Reline complete lower denture (laboratory) [10]	$47.70
D5760	Reline upper partial denture (laboratory) [10]	$41.40
D5761	Reline lower partial denture (laboratory)[10]	$41.40

[10] Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2 year period

D6210	Pontic - cast high noble metal	$175.50
D6211	Pontic - cast predominantly base metal	$82.80
D6212	Pontic - cast noble metal	$89.10
D6240	Pontic - porcelain fused to high noble metal	$180.00
D6241	Pontic - porcelain fused to predominately base metal	$91.80
D6242	Pontic - porcelain fused to noble metal	$95.40
D6250	Pontic - resin with high noble metal	$98.10
D6251	Pontic - resin with predominately base metal	$85.50
D6252	Pontic - resin with noble metal	$89.10
D6602	Inlay - cast high noble metal, two surfaces[11]	$79.20
D6603	Inlay - cast high noble metal, three or more surfaces[11]	$85.50
D6604	Inlay - cast predominantly base metal two surfaces[11]	$79.20
D6605	Inlay - cast predominantly base metal three or more surfaces[11]	$85.50
D6606	Inlay - cast noble metal, two surfaces[11]	$79.20
D6607	Inlay - cast noble metal, three or more surfaces[11]	$85.50
D6720	Crown - resin with high noble metal[11]	$98.10
D6721	Crown - resin with predominately base metal[11]	$85.50
D6722	Crown - resin with noble metal[11]	$89.10
D6750	Crown - porcelain fused to high noble metal[11]	$180.00
D6751	Crown - porcelain fused to predominantly base metal[11]	$91.80
D6752	Crown - porcelain fused to noble metal[11]	$95.40
D6780	Crown - 3/4 cast high noble metal[11]	$91.80
D6790	Crown - full cast high noble metal[11]	$175.50
D6791	Crown - full cast predominately base metal[11]	$85.50
D6792	Crown - full cast noble metal[11]	$89.10

[11] Bridge retainers - initial placement of replacement.

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PROCEDURES NOT LISTED ON THE SCHEDULE MAY BE CHARGED AT THE DENTIST'S USUAL AND CUSTOMARY FEE.

Limitations & Exclusions

Major restorative limitations:

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

- A denture, partial denture, or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy. However, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
- The replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
- The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
- The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
- The replacement of teeth up to the normal complement of 32.

Exclusions:

Benefits will not be paid for:

- Procedures that are not included in the Schedule of Benefits; that are not medically necessary; that do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
- Any procedure, service, or supply that may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling;
- Appliances, inlays, cast restorations, or other laboratory prepared restorations used primarily for the purpose of splinting;
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
- Pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of Your immediate family;
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
- Charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
- Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
- Charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside of the United States are limited to a maximum of $100 (U.S. dollars) per year;
- The care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
- Treatment for cosmetic purposes - facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- Any services or supplies that do not meet the standards set by the American Dental Association or that are not reasonably necessary, or customarily used, for dental care;
- Procedures that are a covered expense under any other medical plan (established by the employer) that provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- An injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
- Charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, Company will determine the amount. Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors.

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