Humana Dental

State of Florida Employees

Dental plans to choose from:

- Prepaid Plan
- Indemnity Plan

Humana®

FLHHB32HH 0819

Two plans to choose from

Humana is pleased to offer you two 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.

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

Choice of plans

- Prepaid Plan – a managed care plan
- Indemnity Plan – a reimbursement plan

Your cost in monthly premium

People First Benefit plan code	4044*	4084
Dental plan name	Prepaid	Indemnity
Employee only	$12.64	$14.74
Employee + spouse	$21.20	$21.96
Employee + child(ren)	$23.00	$23.30
Employee + family	$32.98	$37.10

If you have questions, visit our website at **HumanaDental.com/custom/fl/** or call **1-866-879-3630 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

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

* Please note the Humana Select 15 Prepaid plan/People First Benefit plan code 4044 will be known as the Humana HD205 Prepaid plan/People First Benefit plan code 4044 effective January 1, 2020.

A dental plan that will make you smile

How do the plans work?

Prepaid covers 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 Prepaid plan, the participating specialist's fees may be discounted at 25%. General dentistry and specialty services are available only in areas where Humana has a participating general dentist and/or specialist.

Indemnity covers preventive care and other dental procedures as listed when you're treated by any dentist you choose. You'll be responsible for expenses not reimbursed by the plan and there are benefit maximums.

Do I have to file a claim form?

Prepaid: No, all treatment will be coordinated by your primary care dentist. You're only responsible for the copayment listed on the benefits schedule.

Indemnity: Yes, you must submit a claim form to be reimbursed for your dental expenses.

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?

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

Indemnity: You can see any dentist.

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 visit a dentist close to a workplace, a dependent college student living away from home might pick a dentist near school, and parents might choose to send their children to pediatric dentists (specialist) who are more comfortable treating young children.

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

Visit our website at **HumanaDental.com/custom/fl/** or contact Humana by calling **1-866-879-3630 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

HD205 Prepaid Plan
People First Plan Code #4044

The **HD205 Prepaid Plan** focuses on maintaining oral health, prevention and cost containment. Members may see a participating primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. The HD plan copayments for listed procedures are applicable only at a participating general dentist. For procedures not listed on the summary of services, members may be eligible to receive up to a 25 percent discount.

Member costs listed here are for services provided by a selected participating primary care general dentist (PCD) only. A PCD may decide that a member needs to see a participating specialist. No referral is necessary to see a participating specialist.

Selecting a participating primary care general dentist

For participating dentist information, you may visit our website **Humanadental.com/custom/fl/** or call our dedicated Customer Care number at 1-866-879-3630 (TTY: 711). Once you become enrolled in the HD205 prepaid plan, you will need to select a participating primary care general dentist by registering at **www.mycompbenefits.com** or by calling our dedicated Customer Care number at 1-866-879-3630 (TTY: 711).

Specialists : Should members need a specialist (i.e., endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Members may be eligible to receive up to a 25% discount by visiting a participating specialist. Specialist services are available only in areas where the dental plan has a participating specialist.

Summary of services

Services marked with a single asterisk (*) below also require separate payment of laboratory charges, not to exceed $200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

Appointments	Member pays
D9310 Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$5.00
D9430 Office visit (normal hours)	no charge
D9440 Office visit (after regularly scheduled hours)	$35.00
D9986 Missed appointment	$10.00
D9987 Cancelled appointment	$10.00
D9999 Emergency visit during regularly scheduled hours, by report	$20.00

Diagnostic	Member pays
D0120 Periodic oral examination (limited to twice in any 12 calendar months)	no charge
D0140 Limited oral evaluation—problem focused	no charge
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge
D0150 Comprehensive oral evaluation - new or established patient (limited to twice in any 12 calendar months)	no charge

Diagnostic (Cont.)	Member pays
D0160 Detailed and extensive oral evaluation—problem focused, by report	no charge
D0170 Re-evaluation—problem focused (not post-operative visit)	no charge
D0180 Comprehensive periodontal evaluation (limited to twice in any 12 calendar months)	$15.00
D0210 X-ray intraoral—complete series including bitewings (once per three calendar years)	no charge
D0220 X-ray intraoral—periapical, first radiographic image	no charge
D0230 X-ray intraoral—periapical, each additional radiographic image	no charge
D0240 X-rays intraoral—occlusal radiographic image(s)	no charge
D0250 Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector	no charge
D0270 X-ray bitewing—single radiographic image (limited to twice in any 12 calendar months)	no charge
D0272 X-ray bitewings—two radiographic images (limited to twice in any 12 calendar months)	no charge

Diagnostic (Cont.) — Member pays

D0273 X-ray bitewings—three radiographic images (limited to twice in any 12 calendar months) . . . . . no charge
D0274 Bitewings—four radiographic images (limited to twice in any 12 calendar months) . . no charge
D0277 X-ray bitewings, vertical—seven to eight radiographic images (limited to twice in any 12 calendar months) . . . . . no charge
D0330 Panoramic radiographic image (once per three calendar years) . . . . . no charge
D0350 Oral/facial photography images . . . . . no charge
D0415 Collect microorganisms culture & sensitivity . . no charge
D0425 Caries susceptibility tests . . . . . no charge
D0431 Oral cancer screening using a special light source $50.00
D0460 Pulp vitality tests (not covered if a root canal is performed) . . . . . no charge
D0470 Diagnostic casts . . . . . no charge
D0472 Pathology report - gross examination of lesion . . . . . no charge
D0473 Pathology report—microscopic examination of lesion . . . . . no charge
D0474 Pathology report—microscopic examination of lesion and area . . . . . no charge

Preventive — Member pays

D1110 Prophylaxis—adult, routine (limited to twice in any 12 calendar months, by primary care dentist) . . . . . no charge
D1120 Prophylaxis—child (limited to twice in any 12 calendar months) . . . . . no charge
D1206 Topical application of fluoride varnish (for child <16) (limited to twice in any 12 calendar months) . . . . . no charge
D1208 Topical application of fluoride - excluding varnish (limited to twice in any 12 calendar months) . . . . . no charge
D1310 Nutrition counseling for the control of dental disease . . . . . no charge
D1320 Tobacco counseling services for the control or prevention of oral disease . . . . . no charge
D1330 Oral hygiene instruction . . . . . no charge
D1351 Sealant—per tooth (permanent teeth only to age 16) $10.00
D1510* Space maintainer—fixed, unilateral (through age 14) $50.00
D1516* Space maintainer – fixed – bilateral, maxillary (through age 14) $70.00
D1517* Space maintainer – fixed – bilateral, mandibular (through age 14) $70.00

Preventive (Cont.) — Member pays

D1520* Space maintainer—removable, unilateral (through age 14) $85.00
D1526* Space maintainer - removable - bilateral, maxillary (through age 14) $90.00
D1527* Space maintainer – removable – bilateral, mandibular (through age 14) $90.00
D1550 Re-cement or re-bond space maintainer $10.00
D1575 Distal shoe space maintainer – fixed unilateral (through age 14; primary teeth only) $130.00

Restorative — Member pays

D2140 Amalgam-one surface, primary or permanent $5.00
D2150 Amalgam-two surfaces, primary or permanent $5.00
D2160 Amalgam-three surfaces, primary or permanent $5.00
D2161 Amalgam-four or more surfaces, primary or permanent $5.00
D2940 Protective restoration $10.00

Resin restorative
(inlays and onlays limited to one per tooth every five years) — Member pays

D2330 Resin based composite—one surface, anterior . . $30.00
D2331 Resin based composite—two surfaces, anterior . . $40.00
D2332 Resin based composite–three surfaces, anterior . . $45.00
D2335 Resin based composite—four or more surfaces or involving incisal angle (anterior) $65.00
D2390 Resin based composite crown, anterior $70.00
D2391 Resin based composite—one surface, posterior . . $45.00
D2392 Resin based composite—two surfaces, posterior . . $55.00
D2393 Resin based composite—three surfaces, posterior $80.00
D2394 Resin based composite—four or more surfaces, posterior $90.00
D2510* Inlay—metallic, one surface $225.00
D2520* Inlay—metallic, two surfaces $235.00
D2530* Inlay—metallic, three or more surfaces $245.00
D2542* Onlay—metallic, two surfaces $250.00
D2543* Onlay—metallic, three surfaces $260.00
D2544* Onlay—metallic, four or more surfaces $270.00
D2610* Inlay—porcelain/ceramic, one surface $250.00
D2620* Inlay—porcelain/ceramic, two surfaces $260.00
D2630* Inlay—porcelain/ceramic, three or more surfaces $270.00
D2642* Onlay—porcelain/ceramic, two surfaces $275.00
D2643* Onlay—porcelain/ceramic, three surfaces $285.00

Resin restorative (Cont.)

(inlays and onlays limited to one per tooth every five years) **Member pays**

D2644* Onlay—porcelain/ceramic, four or more surfaces $295.00
D2650* Inlay—resin based composite, one surface $225.00
D2651* Inlay—resin based composite, two surfaces . . . $235.00
D2652* Inlay—resin based composite, three or more surfaces $245.00
D2662* Onlay—resin based composite, two surfaces . . $250.00
D2663* Onlay—resin based composite, three surfaces . . $260.00
D2664* Onlay—resin based composite, four or more surfaces $270.00

Crown and bridge

(limited to one per tooth every five years) **Member Pays**

D2710* Crown—resin based composite, indirect $270.00
D2712* Crown—3/4 resin based composite, indirect . . . $270.00
D2720* Crown—resin with high noble metal $270.00
D2721 Crown—resin with predominantly base metal . . $270.00
D2722* Crown—resin with noble metal $270.00
D2740* Crown—porcelain/ceramic $270.00
D2750* Crown—porcelain fused to high noble metal . . $270.00
D2751 Crown—porcelain fused to predominantly base metal $270.00
D2752* Crown—porcelain fused to noble metal $270.00
D2780* Crown—3/4 cast high noble metal $270.00
D2781 Crown—3/4 cast predominantly base metal . . . $270.00
D2782* Crown—3/4 cast noble metal $270.00
D2783* Crown—3/4 porcelain/ceramic $270.00
D2790* Crown—full cast high noble metal $270.00
D2791 Crown—full cast predominantly base metal . . . $270.00
D2792* Crown—full cast noble metal $270.00
D2794* Crown—titanium $270.00
D2799 Provisional crown . . . . . no charge
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration $15.00
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core . . . . . no charge
D2920 Re-cement or re-bond crown $15.00
D2929 Crown-Prefabricated porcelain/ceramic crown—primary tooth $75.00
D2930 Prefabricated stainless steel crown—primary tooth $75.00
D2931 Prefabricated stainless steel crown—permanent tooth $25.00

Crown and bridge (Cont.)

(limited to one per tooth every five years) **Member Pays**

D2932 Prefabricated resin crown $50.00
D2933 Prefabricated stainless steel crown with resin window $50.00
D2934 Prefabricated esthetic coated stainless steel crown—primary tooth $50.00
D2950 Core buildup, including any pins $50.00
D2951 Pin retention—per tooth, in addition to restoration $15.00
D2952* Cast post and core in addition to crown $95.00
D2953* Each additional cast post—same tooth $100.00
D2954 Prefabricated post and core in addition to crown $85.00
D2955 Post removal (not in conjunction with endodontic therapy) $10.00
D2957 Each additional prefabricated post—same tooth, base metal post $35.00
D2960 Labial veneer (resin laminate)—chairside $250.00
D2961* Labial veneer (resin laminate)—laboratory $300.00
D2962* Labial veneer (porcelain laminate)—laboratory . . $350.00
D2971 Additional procedure—new crown existing partial denture $50.00
D2980 Crown repair, necessitated by restorative material failure . . . . . no charge
D2981 Inlay repair, necessitated by restorative material failure . . . . . no charge
D2982 Onlay repair, necessitated by restorative material failure . . . . . no charge
D2983 Veneer repair, necessitated by restorative material failure . . . . . no charge
D6940 Stress breaker $150.00
D6950 Precision attachment, separate from prosthesis $195.00

Prosthodontics-fixed

(replacement limited to every five years, adjustments once per year) **Member Pays**

D6210* Pontic—cast high noble metal $270.00
D6211 Pontic—cast predominantly base metal $270.00
D6212* Pontic—cast noble metal $270.00
D6240* Pontic—porcelain fused to high noble metal . . . $270.00
D6241 Pontic—porcelain fused to predominantly base metal $270.00
D6242* Pontic—porcelain fused to noble metal $270.00
D6750* Crown—porcelain fused to high noble metal . . $270.00

Prosthodontics-fixed (Cont.)

(replacement limited to every five years, adjustments once per year) **Member Pays**

D6751 Crown—porcelain fused to predominantly base metal $270.00
D6752* Crown—porcelain fused to noble metal $270.00
D6790* Retainer crown—full cast high noble metal. . . . $270.00
D6791 Retainer crown—full cast predominantly base metal $270.00
D6792* Retainer crown—full cast noble metal $270.00
D6794* Retainer crown—titanium $270.00
D6930 Re-cement or re-bond fixed partial denture (per unit). $15.00

Prosthodontics

(replacement limited to every five years) **Member Pays**

D5110* Complete denture—maxillary. $375.00
D5120* Complete denture—mandibular $375.00
D5130* Immediate denture—maxillary $375.00
D5140* Immediate denture—mandibular $375.00
D5211* Maxillary partial denture-resin base (including retentive/clasping materials, rests and teeth) $400.00
D5212* Mandibular partial denture-resin base (including retentive/clasping materials, rests and teeth) $400.00
D5213* Maxillary partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth) $425.00
D5214* Mandibular partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth) $425.00
D5221 Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth) $263.00
D5222 Immediate mandibular partial denture-resin base (including any conventional clasps, rests and teeth) $263.00
D5223 Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $413.00
D5224 Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $413.00
D5225* Maxillary partial denture—flexible (including clasps, rests and teeth) $425.00

Prosthodontics (Cont.)

(replacement limited to every five years) **Member Pays**

D5226* Mandibular partial denture—flexible (including clasps, rests and teeth) $425.00
D5282* Removable unilateral partial denture - one piece metal (including clasps and teeth), maxillary $350.00
D5283* Removable unilateral partial denture - one piece metal (including clasps and teeth), mandibular $350.00
D5410 Adjust complete denture—maxillary $15.00
D5411 Adjust complete denture—mandibular $15.00
D5421 Adjust partial denture—maxillary $15.00
D5422 Adjust partial denture—mandibular $15.00
D5660* Add clasp to existing partial denture—per tooth $90.00

Endodontics

(each procedure limited to once per tooth per life) **Member Pays**

D3110 Pulp cap—direct (excluding final restoration) . . $15.00
D3120 Pulp cap—indirect (excluding final restoration) $10.00
D3220 Therapeutic pulpotomy (excluding final restoration) $40.00
D3221 Pulpal debridement, primary and permanent teeth (not to be used when root canal is done on the same day). $85.00
D3230 Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration) $45.00
D3240 Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration) $50.00
D3310 Root canal therapy—anterior tooth (excluding final restoration) $110.00
D3320 Endodontic therapy, premolar tooth (excluding final restorations) $195.00
D3330 Endodontic therapy, molar tooth (excluding final restorations) $250.00
D3331 Treatment of root canal obstruction—non-surgical access $80.00
D3332 Incomplete endodontic therapy—inoperable or fractured tooth $80.00
D3333 Internal root repair of perforation defects. $90.00
D3351 Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.). $90.00

Endodontics (Cont.)

(each procedure limited to once per tooth per life) — **Member Pays**

D3352 Apexification/recalcification—interim medication replacement (includes any necessary radiographs) $80.00

D3353 Apexification/recalcification—final visit (includes any necessary radiographs). $90.00

D3410 Apicoectomy—anterior $135.00

D3421 Apicoectomy—premolar (first root). $120.00

D3425 Apicoectomy—molar (first root). $120.00

D3426 Apicoectomy—(each additional root) $60.00

D3430 Retrograde filling—per root. $40.00

D3450 Root amputation—per root (not covered in conjunction with procedure D3920) $95.00

D3910 Surgical procedure to isolate tooth with rubbed dam $20.00

D3920 Hemisection not included in root canal therapy $90.00

D3950 Canal preparation and fitting of preformed dowel or post $15.00

Periodontics-gum treatment — Member pays

D4210 Gingivectomy/gingivoplasty–four or more contiguous teeth or tooth bounded spaces per quadrant. $120.00

D4211 Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant. $55.00

D4240 Gingival flap, including root planing—four or more teeth, per quadrant $150.00

D4241 Gingival flap, including root planing—one to three teeth, per quadrant. $120.00

D4245 Apically positioned flap $175.00

D4249 Clinical crown lengthening—hard tissue $150.00

D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant $350.00

D4261 Osseous surgery (including elevation of a full thickness flap and closure) one to three contiguous teeth or tooth bounded spaces per quadrant. $325.00

D4263 Bone replacement graft—retained natural tooth—first site in quadrant $180.00

D4264 Bone replacement graft—retained natural tooth—each additional site in quadrant $95.00

D4265 Biological materials which can aid soft and osseous tissue regeneration $95.00

Periodontics-gum treatment (Cont.) — Member pays

D4266 Guided tissue regeneration—resorbable barrier, per site. $230.00

D4267 Guided tissue regeneration—non resorbable barrier, per site (includes membrane removal) $275.00

D4270 Pedicle soft tissue graft procedure. $260.00

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft. $350.00

D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) $90.00

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft. $380.00

D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft $265.00

D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site $130.00

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site. $210.00

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site $228.00

D4320 Provisional splinting—intracoronal $95.00

D4321 Provisional splinting—extracoronal. $85.00

D4341 Periodontal scaling and root planing – four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months). $55.00

D4342 Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months) $50.00

Periodontics-gum treatment (Cont.) — Member pays

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120) $55.00

D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years) $50.00

D4381 Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy) $60.00

D4910 Periodontal maintenance (covered only after active periodontal therapy) $45.00

Repairs to prosthetics — Member Pays

D5511* Repair broken complete denture base, mandibular $35.00

D5512* Repair broken complete denture base, maxillary $35.00

D5520* Replace missing or broken teeth—complete denture (each tooth) $35.00

D5611* Repair resin partial denture base, mandibular .. $35.00

D5612* Repair resin partial denture base, maxillary ... $35.00

D5621* Repair cast partial framework, mandibular $35.00

D5622* Repair cast partial framework, maxillary $35.00

D5630* Repair or replace broken retentive clasping materials—per tooth $35.00

D5640* Replace broken teeth—per tooth $35.00

D5650* Add tooth to existing partial denture $35.00

D5670* Replace all teeth and acrylic on cast metal framework—maxillary $210.00

D5671* Replace all teeth and acrylic on cast metal framework—mandibular $225.00

D5710* Rebase complete maxillary denture $200.00

D5711* Rebase complete mandibular denture $200.00

D5720* Rebase maxillary partial denture $200.00

D5721* Rebase mandibular partial denture $200.00

D5730 Reline complete maxillary denture (chairside).. $60.00

D5731 Reline complete mandibular denture (chairside) $60.00

D5740 Reline maxillary partial denture (chairside) $60.00

D5741 Reline mandibular partial denture (chairside).. $60.00

D5750* Reline complete maxillary denture (laboratory) $95.00

Repairs to prosthetics (Cont.) — Member Pays

D5751* Reline complete mandibular denture (laboratory) $95.00

D5760* Reline maxillary partial denture (laboratory) .. $95.00

D5761* Reline mandibular partial denture (laboratory).. $95.00

D5810* Interim complete denture (maxillary) $250.00

D5811* Interim complete denture (mandibular) $250.00

D5820* Interim partial denture (maxillary) $80.00

D5821* Interim partial denture (mandibular) $80.00

D5850 Tissue conditioning, maxillary $30.00

D5851 Tissue conditioning, mandibular $30.00

D6214* Pontic titanium $270.00

D6245* Pontic—porcelain/ceramic $270.00

D6250* Pontic—resin with high noble metal $270.00

D6251 Pontic—resin with predominantly base metal.. $270.00

D6252* Pontic—resin with noble metal $270.00

D6253* Provisional pontic ..... no charge

D6545* Retainer—cast metal, resin bonded fixed prosthesis $250.00

D6548* Retainer —porcelain/ceramic, resin bonded fixed prosthesis $250.00

D6549 Resin retainer – for resin bonded fixed prosthesis $250.00

D6600* Retainer inlay—porcelain/ceramic, two surfaces $270.00

D6601* Retainer inlay—porcelain/ceramic, three or more surfaces $270.00

D6602* Retainer inlay—cast high noble metal, two surfaces $270.00

D6603* Retainer inlay—cast high noble metal, three or more surfaces $270.00

D6604 Retainer inlay—cast predominantly base metal, two surfaces $270.00

D6605 Retainer inlay—cast predominantly base metal, three or more surfaces $270.00

D6606* Retainer inlay—cast noble metal, two surfaces . $270.00

D6607* Retainer inlay—cast noble metal, three or more surfaces $270.00

D6608* Retainer onlay—porcelain/ceramic, two surfaces $270.00

D6609* Retainer onlay—porcelain/ceramic, three or more surfaces $270.00

D6610* Retainer onlay—cast high noble metal, two surfaces $270.00

D6611* Retainer onlay—cast high noble metal, three or more surfaces $270.00

D6612 Retainer onlay—cast predominantly base metal, two surfaces $270.00

Repairs to prosthetics (Cont.) — Member Pays

D6613 Retainer onlay—cast predominantly base metal, three or more surfaces $270.00
D6614* Retainer onlay—cast noble metal, two surfaces $270.00
D6615* Retainer onlay—cast noble metal, three or more surfaces $270.00
D6624* Retainer inlay titanium $270.00
D6634* Retainer onlay titanium $270.00
D6710* Retainer crown—indirect resin based composition $270.00
D6720* Retainer crown—resin with high noble metal $270.00
D6721 Retainer crown—resin with predominantly base metal $270.00
D6722* Retainer crown—resin with noble metal $270.00
D6740* Retainer crown—porcelain/ceramic $280.00
D6780* Retainer crown—3/4 cast high noble metal $270.00
D6781 Retainer crown—3/4 cast predominantly base metal $270.00
D6782* Retainer crown—3/4 cast noble metal $270.00
D6783* Retainer crown—3/4 porcelain ceramic, denture $270.00

Extractions/oral and maxillofacial surgery — Member pays

D7111 Extraction, coronal remnants – primary tooth ..... no charge
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ..... no charge
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated $40.00
D7220 Removal of impacted tooth—soft tissue $55.00
D7230 Removal of impacted tooth—partially bony $70.00
D7240 Removal of impacted tooth—completely bony $85.00
D7241 Removal of impacted tooth—completely bony, unusual complications by report $110.00
D7250 Surgical removal of residual tooth roots $40.00
D7260 Oroantral fistula closure $350.00
D7261 Primary closure of a sinus perforation $225.00
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth $55.00
D7280 Exposure of an unerupted tooth (excluding wisdom teeth) $100.00
D7282 Mobilization of erupted or malposed tooth to aid eruption $90.00
D7285 Incisional biopsy of oral tissue-hard bone, tooth) $350.00

Extractions/oral and maxillofacial surgery (Cont.) — Member pays

D7286 Incisional biopsy of oral tissue-soft (all others) $120.00
D7287 Exfoliative cytological sample collection $50.00
D7288 Brush biopsy—transepithelial sample collection $55.00
D7310 Alveoloplasty in conjunction with extractions—per quadrant $40.00
D7311 Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant $15.00
D7320 Alveoloplasty not in conjunction with extractions—per quadrant $75.00
D7321 Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant $30.00
D7450 Removal of benign odontogenic cyst or tumor—up to 1.25 cm $160.00
D7451 Removal of benign odontogenic cyst or tumor—greater than 1.25 cm $235.00
D7471 Removal of lateral exostosis (maxilla or mandible) $90.00
D7472 Removal of torus palatinus $65.00
D7473 Removal of torus mandibularis $65.00
D7485 Reduction of osseous tuberosity $60.00
D7510 Incision and drainage of abscess—intraoral soft tissue $35.00
D7970 Excision hyperplastic tissue—per arch $85.00
D7971 Excision of pericoronal gingival $55.00

Adjunctive general service — Member pays

D9110 Palliative (emergency) treatment of dental pain—minor procedure $20.00
D9215 Local anesthesia in conjunction with operative or surgical procedures ..... no charge
D9222 Deep sedation/general anesthesia – first 15 minutes $83.00
D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment $71.00
D9230 Inhalation of nitrous oxide analgesia, anxiolysis $15.00
D9239 Intravenous moderate (conscious) sedation/analgesia – first 15 minutes $83.00
D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment $71.00
D9450 Case presentation, detailed and extensive treatment planning ..... no charge
D9951 Occlusal adjustment—limited $35.00
D9952 Occlusal adjustment—complete $165.00

Bleaching	Member pays
D9972 External bleaching in office—per arch	$175.00
D9975 External bleaching in home—per arch	$175.00

Orthodontics

NOTE: Members may receive up to a 25 percent discount by visiting a participating orthodontist.

NOTE:

- No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered except out-of-area emergency care as provided in the certificate of benefits.
- No coverage for any dental treatment started prior to the Member's effective date.
- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures)
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits.

Insured or administered by CompBenefits Company.

Schedule B Indemnity Plan
People First Plan Code #4084

Schedule of benefits

Calendar year deductible	
Type I, II, III	$0 individual $0 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 Reinbursement
TYPE I – Preventive Dental Services		
D0120	Periodic oral examination—established patient	$23
D0140	Limited oral evaluation—problem focused[1]	$31
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver[1]	$31
D0150	Comprehensive oral evaluation - new or established patient[1]	$31
D0180	Comprehensive periodontal evaluation - new or established patient[1]	$31
D0210	X-ray intraoral—complete series of radiographic images (once per three year period)	$61
D0220	X-ray intraoral—periapical, first radiographic image	$13
D0230	X-ray intraoral—periapical, each additional radiographic image	$13
D0240	X-rays intraoral—occlusal radiographic image.	$16
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$22
D0251	Extra-oral posterior dental radiographic image[1]	$32
D0270	X-ray bitewing—single radiographic image[1]	$20
D0272	X-ray bitewings—two radiographic images[1]	$25
D0273	Bitewings – three radiographic images[1]	$32
D0274	Bitewings—four radiographic images[1]	$32
D0330	Panoramic radiographic image (covered once per three year period)	$47
D0415	Collection of microorganisms for culture & sensitivity	$36
D1110	Prophylaxis—adult[1]	$38
D1120	Prophylaxis—child[1]	$36
D1206	Topical application of fluoride varnis (Covered twice per 12 consecutive months for a dependent child under 16).	$31
D1208	Topical application of fluoride – excluding varnish (Covered twice per 12 consecutive months for a dependent child under 16)	$31

ADA CODE	Procedure	Maximum Reinbursement
D1351	Sealant—per tooth (Covered once per 12 consecutive months for a dependent child under age 13)	$13
D1510	Space maintainer—fixed, unilateral	$160
D1515	Space maintainer—fixed, bilateral	$216
D1520	Space maintainer—removable, unilateral	$202
D1525	Space maintainer—removable, bilateral.	$220
D1550	Re-cement or re-bond space maintainer.	$27
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$90
D7286	Incisional biopsy of oral tissue-soft	$61
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$29
TYPE II – Basic Dental Services		
D2140	Amalgam—one surface, primary or permanent[2]	$19
D2150	Amalgam—two surfaces, primary or permanent[2]	$29
D2160	Amalgam—three surfaces, primary or permanent[2]	$36
D2161	Amalgam—four or more surfaces, primary or permanent[2].	$46
D2330	Resin based composite—one surface, anterior[3]	$24
D2331	Resin based composite—two surfaces, anterior[3]	$36
D2332	Resin based composite—three surfaces, anterior[3]	$49
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)[3]	$46
D2391	Resin based composite—one surface, posterior[3]	$19
D2392	Resin based composite—two surfaces, posterior[3]	$29
D2393	Resin based composite—three surfaces, posterior[3]	$36
D2394	Resin based composite—four or more surfaces, posterior[3] .	$36
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$19
D2920	Re-cement or re-bond crown	$19
D2940	Protective restoration (Covered as separate procedure if no other service, except X-rays, rendered during the visit).	$20

[1] Covered twice per 12 consecutive months

[2] Multiple restorations on one surface will be covered as a single filling

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

ADA CODE	Procedure	Maximum Reinbursement
D2950	Core buildup, including any pins when required	$58
D2951	Pin retention—per tooth, in addition to restoration	$27
D3220	Therapeutic pulpotomy (excluding final restoration)	$33
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$33
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$259
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$317
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$389
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$73
D3352	Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	$73
D3353	Apexification/recalcification—final visit (includes any necessary radiographs)	$73
D3410	Apicoectomy—anterior	$114
D3421	Apicoectomy—premolar (first root)	$114
D3425	Apicoectomy—molar (first root)	$114
D3426	Apicoectomy (each additional root)	$114
D3430	Retrograde filling—per root	$42
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	$62
D3920	Hemisection (including any root removal), not including root canal therapy	$62
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$82
D4211	Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4]	$22
D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92
D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4]	$92
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)	$153
D4270	Pedicle soft tissue graft procedure (Covered once per 12 consecutive months)	$92
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft (Covered once per 12 consecutive months)	$102
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site (Covered once per 12 consecutive months)	$102
D4320	Provisional splinting—intracoronal	$29
D4321	Provisional splinting—extracoronal	$29
D4341	Periodontal scaling and root planing – four or more teeth per quadrant[5]	$23
D4342	Periodontal scaling and root planing – one to three teeth per quadrant[5]	$23
D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit[5]	$49
D4910	Periodontal maintenance (covered only after active periodontal therapy)[5]	$32
D5511	Repair broken complete denture base, mandibular[6]	$42
D5512	Repair broken complete denture base, maxillary[6]	$42
D5520	Replace missing or broken teeth—complete denture (each tooth)[6]	$42
D5611	Repair resin partial denture base, mandibular[6]	$42
D5612	Repair resin partial denture base, maxillary[6]	$42
D5621	Repair cast partial framework, mandibular[6]	$42
D5622	Repair cast partial framework, maxillary[6]	$42
D5630	Repair or replace broken clasp—per tooth[6]	$49
D5640	Replace broken teeth—per tooth[6]	$30
D5650	Add tooth to existing partial denture[6]	$58
D5660	Add clasp to existing partial denture—per tooth[6]	$62
D5710	Rebase complete maxillary denture[6]	$122
D5711	Rebase complete mandibular denture[6]	$122
D5720	Rebase maxillary partial denture[6]	$122
D5721	Rebase mandibular partial denture[6]	$122

[4] Only one of these procedures is covered per area of the mouth.
[5] Covered twice per area of the mouth per 12 consecutive months.
[6] Covered only if repairs/adjustments more than 1 year after the initial insertion.

ADA CODE	Procedure	Maximum Reinbursement
D6930	Re-cement or re-bond fixed partial denture (per unit)	$26
D7111	Extraction, coronal remnants – primary tooth	$23
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$23
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$42
D7220	Removal of impacted tooth—soft tissue	$58
D7230	Removal of impacted tooth—partially bony	$73
D7240	Removal of impacted tooth—completely bony	$98
D7250	Surgical removal of residual tooth roots (cutting procedure)	$46
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$76
D7272	Tooth transplantation (includes re- implantation from one site to another and splinting and/or stabilization)	$82
D7310	Alveoloplasty in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$35
D7320	Alveoloplasty not in conjunction with extractions— four or more teeth or tooth spaces, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$40
D7340	Vestibuloplasty – ridge extension (second epithelialization)	$62
D7350	Vestibuloplasty – ridge extension (including tissue procedures)	$122
D7510	Incision and drainage of abscess— intraoral soft tissue	$36
D7520	Incision and drainage of abscess – extraoral soft tissue	$55
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$53
D7970	Excision hyperplastic tissue—per arch	$62
D9222	Deep sedation/general anesthesia – first 15 minute[7]	$54
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment[7]	$49
D9610	Therapeutic parenteral drug, single administration	$19
D9951	Occlusal adjustment – limited[8]	$23
D9952	Occlusal adjustment – complete[8]	$59

TYPE III – Major Dental Services

ADA CODE	Procedure	Maximum Reinbursement
D0470	Diagnostic casts	$24
D2510	Inlay—metallic, one surface	$92
D2520	Inlay—metallic, two surfaces	$127
D2530	Inlay—metallic, three or more surfaces	$137
D2610	Inlay—porcelain/ceramic, one surface	$42
D2620	Inlay—porcelain/ceramic, two surfaces	$84
D2630	Inlay—porcelain/ceramic, three or more surfaces	$125
D2710	Crown—resin based composite, indirect	$82
D2720	Crown—resin with high noble metal	$157
D2721	Crown—resin with predominantly base metal	$137
D2722	Crown—resin with noble metal	$143
D2740	Crown—porcelain/ceramic	$153
D2750	Crown—porcelain fused to high noble metal	$288
D2751	Crown—porcelain fused to predominantly base metal	$147
D2752	Crown—porcelain fused to noble metal	$153
D2790	Crown—full cast high noble metal	$281
D2791	Crown—full cast predominantly base metal	$132
D2792	Crown—full cast noble metal	$143
D2930	Prefabricated stainless steel crown— primary tooth	$35
D2931	Prefabricated stainless steel crown—permanent tooth	$35
D2952	Post and core in addition to crown, indirectly fabricated	$58
D2954	Prefabricated post and core in addition to crown	$42
D5110	Complete denture—maxillary	$207
D5120	Complete denture—mandibular	$207
D5130	Immediate denture—maxillary	$217
D5140	Immediate denture—mandibular	$217
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	$127
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	$127
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233

[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.

ADA CODE	Procedure	Maximum Reinbursement
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$127
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$127
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$233
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$215
D5281	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	$46
D5410	Adjust complete denture—maxillary[9]	$13
D5411	Adjust complete denture—mandibular[9]	$13
D5421	Adjust partial denture—maxillary[9]	$13
D5422	Adjust partial denture—mandibular[9]	$13
D5730	Reline complete maxillary denture (chairside)[10]	$52
D5731	Reline complete mandibular denture (chairside)[10]	$52
D5740	Reline maxillary partial denture (chairside)[10]	$42
D5741	Reline mandibular partial denture (chairside)[10]	$42
D5750	Reline complete maxillary denture (laboratory)[10]	$76
D5751	Reline complete mandibular denture (laboratory)[10]	$76
D5760	Reline maxillary partial denture (laboratory)[10]	$66
D5761	Reline mandibular partial denture (laboratory)[10]	$66
D6210	Pontic—cast high noble metal	$281
D6211	Pontic—cast predominantly base metal	$132
D6212	Pontic—cast noble metal	$143
D6240	Pontic—porcelain fused to high noble metal	$288
D6241	Pontic—porcelain fused to predominantly base metal	$147
D6242	Pontic—porcelain fused to noble metal	$153
D6250	Pontic—resin with high noble metal	$157
D6251	Pontic—resin with predominantly base metal	$137
D6252	Pontic—resin with noble metal	$143
D6602	Retainer inlay—cast high noble metal, two surfaces[11]	$127
D6603	Retainer inlay—cast high noble metal, three or more surfaces[11]	$137
D6604	Retainer inlay—cast predominantly base metal, two surfaces[11]	$127
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces[11]	$137
D6606	Retainer inlay—cast noble metal, two surfaces[11]	$127
D6607	Retainer inlay—cast noble metal, three or more surfaces[11]	$137
D6720	Retainer crown—resin with high noble metal[11]	$157
D6721	Retainer crown—resin with predominantly base metal[11]	$137
D6722	Retainer crown—resin with noble metal[11]	$143
D6750	Retainer crown—porcelain fused to high noble metal[11]	$288
D6751	Retainer crown—porcelain fused to predominantly base metal[11]	$147
D6752	Retainer crown—porcelain fused to noble metal[11]	$153
D6780	Retainer crown—3/4 cast high noble metal[11]	$147
D6790	Retainer crown—full cast high noble metal[11]	$281
D6791	Retainer crown—full cast predominantly base metal[11]	$137
D6792	Retainer crown—full cast noble metal[11]	$143

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

[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.

[11] Bridge retainers – initial placement of replacement.

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

Limitations and 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, 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; the degree of professional skill required; and (c) other pertinent factors.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)

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