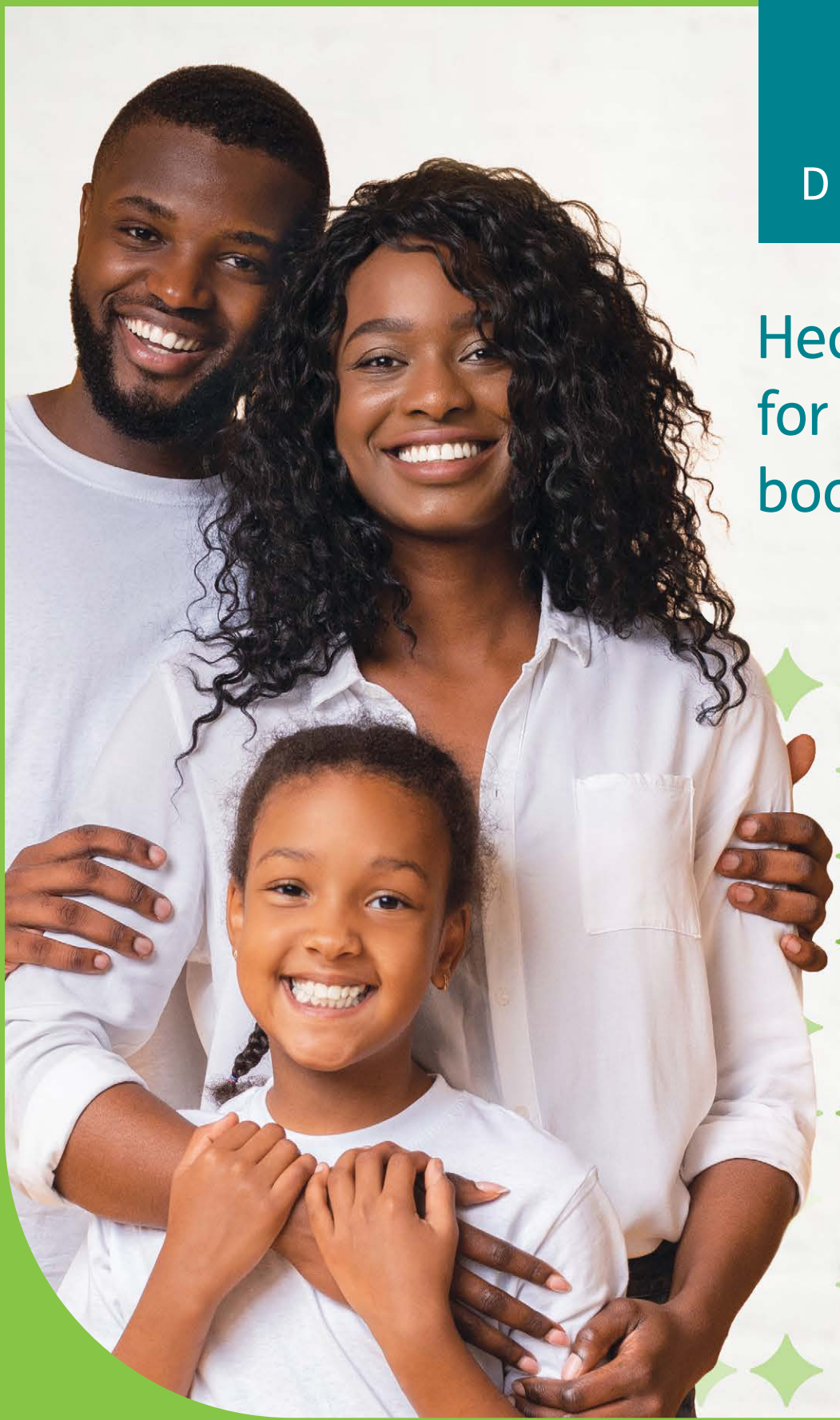


DENTAL

Healthy smiles for healthy bodies

Humana®

Department of MANAGEMENT SERVICES
Division of State Group Insurance

State of Florida employees

2025 Plan year

Our dental plans will make you smile

At Humana we want to help take care of you. Dental health is an important part of your overall well-being, and Humana's dental benefits help make it easy to make your dental care a priority. When you sign up for a Humana dental plan, you're signing up for a healthier you.

Why sign up for dental benefits?

If you've never bought dental insurance before, **you'll be pleasantly surprised at the monthly cost.**

Preventive dental care, such as check-ups and cleanings, help stop issues before they start saving you time and money in the long run. And when you use an in-network dentist, **preventive care is at no additional cost to you.**

For years, doctors have recognized the link between oral health and whole-body health. **Routine teeth cleanings can help reduce your risk for heart disease, stroke and dementia.**

Plus, **caring for you is at the heart of everything we do** so we make it easy for you to get the help you need – when you need it. Our service teams are always ready to help and answer your questions.

Review the benefit information in this guide to help you choose a dental plan that's right for you.

You have many dental plan benefit choices

Humana is pleased to offer you a variety of dental plan options. The PPO options offer a network of dentists where you can get our best pricing for dental services when you visit in-network dentists. While some of the benefits for all the plan options 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.

Choice of plans

- Prepaid plan – a managed care plan
- Schedule B indemnity plan – a reimbursement plan
- Three PPO plans – traditional plan with in-network dental rates

Your cost in monthly premium

			Compare our premium rates to other PPO plans		
People First Benefit plan code	**4044**	**4084**	**4094**	**4092**	**4090**
Dental plan name	Prepaid	Schedule B indemnity	Preventive PPO	Standard PPO	Indemnity with PPO
Employee only	$12.64	$14.74	$20.52	$30.64	$45.76
Employee + spouse	$21.20	$21.96	$37.98	$56.70	$84.66
Employee + child(ren)	$23.00	$23.30	$42.44	$63.36	$94.60
Employee + family	$32.98	$37.10	$61.60	$91.98	$137.34

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

How do the dental plans work?

How do the plans work?

PPO dental plans are built with whole-person health in mind. These are more traditional dental insurance plans and feature key benefits for both healthy smiles and bodies along with convenient ways to get care. To get the most out of your plan, visit one of our in-network PPO dentists. This will ensure you get our best pricing for dental care services.

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.

Schedule B 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?

PPO: No, all claims will be coordinated by your dentist. You're only responsible for the deductible and coinsurance listed on the benefits schedule.

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

Schedule B 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.

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 **www.compbenefits.com/custom/stateofflorida/** or contact Humana by calling **866-879-3630 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

How to find a dentist in the network

Visiting a dentist in the Humana network ensures you're getting the lowest cost for dental care. To find an in-network dentist for each plan, select the plan below and enter the information requested, or go to **www.compbenefits.com/custom/stateofflorida/** to review all plans:

Prepaid (4044)

https://www.mycompbenefits.com/pts/do/show/providerSearchCriteria?app=PTS&plan1=HD205&plan2=002

Preventive PPO (4094)

https://www.mycompbenefits.com/pts/do/show/providerSearchCriteria?app=PTS&plan1=SOFPP1&plan2=1

Standard PPO (4092)

https://www.mycompbenefits.com/pts/do/show/providerSearchCriteria?app=PTS&plan1=SOFPP2&plan2=1

Indemnity with PPO (4090)

https://www.mycompbenefits.com/pts/do/show/providerSearchCriteria?app=PTS&plan1=SOFINP&plan2=1

Schedule B indemnity (4084)

You can see any dentist

How do I know which dentist to see?

PPO: To find an in-network dentist visit **www.compbenefits.com/custom/stateofflorida/**.

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

Schedule B indemnity: You can see any dentist.

Humana Dental Preventive PPO

People First Plan Code #4094
State of Florida

	If you use an in-network dentist		If you use an out-of-network dentist	
Calendar-year deductible	**In-network and out-of-network deductibles** Deductible applies to all services excluding preventive.			
	Employee only $50	Employee + spouse $100	Employee + child(ren) $100	Employee + spouse + child(ren) $150
Calendar-year annual maximum	$1,000		$1,000	
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15)	100% no deductible		80% no deductible	
Basic services • Periodontal cleanings (2 per year) • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, anterior teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment) • Denture repair • Denture relines/rebases (1 every 3 years, following 6 months of denture use)	80% after deductible		50% after deductible	

Humana Dental Preventive PPO

People First Plan Code #4094
State of Florida

	If you use an in-network dentist	If you use an out-of-network dentist
Major services • Harmful habit appliances for children (1 per lifetime, through age 14) • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth every 5 years) • Denture adjustments (following 6 months of denture use) • Implants	Not Covered	Not Covered
Orthodontia services	Not Covered	Not Covered

	Preventive	Basic	Major	Orthodontia
Waiting periods Enrollment type: Initial enrollment, open enrollment and timely add-on	No	No	N/A	N/A

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the out of network fee schedule of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Questions?

Simply call **866-879-3630 (TTY: 711)** to speak with a friendly, knowledgeable Customer Care specialist, or visit **www.compbenefits.com/custom/stateofflorida/**.

Humana Dental Standard PPO

People First Plan Code #4092
State of Florida

	If you use an in-network dentist		If you use an out-of-network dentist	
Calendar-year deductible	**In-network and out-of-network deductibles** Deductible applies to all services excluding preventive and orthodontia. Orthodontia has a separate lifetime deductible per person. Please refer to the "Orthodontia services" section for more information.			
	Employee only $50	Employee + spouse $100	Employee + child(ren) $100	Employee + spouse + child(ren) $150
Calendar-year annual maximum	$1,500		$1,500	
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15)	100% no deductible		80% no deductible	
Basic services • Periodontal cleanings (2 per year) • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, anterior teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment) • Denture repair • Denture relines/rebases (1 every 3 years, following 6 months of denture use)	80% after deductible		50% after deductible	

Humana Dental Standard PPO

People First Plan Code #4092
State of Florida

	If you use an in-network dentist	If you use an out-of-network dentist
Major services • Harmful habit appliances for children (1 per lifetime, through age 14) • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth every 5 years) • Denture adjustments (following 6 months of denture use) • Implants (1 per tooth every 5 years)	50% after deductible	30% after deductible
Orthodontia services	Adult/child orthodontia. Plan pays 50% for a participating provider and 30% for a nonparticipating provider ($50 lifetime deductible per person receiving orthodontia services) up to a lifetime orthodontia maximum of $2,000 when the Member receives services from a participating provider and $1,500 when the Member receives services from a non-participating provider.	

	Preventive	Basic	Major	Orthodontia
Waiting periods Enrollment type: Initial enrollment, open enrollment and timely add-on	No	No	No	Yes

**There is a one year waiting period for Type IV services. Creditable coverage will apply toward the waiting period. Waiting period waived for any member who enrolls during the 2022 Open Enrollment period for a January 1, 2023 effective date.*

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the out of network fee schedule of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Questions?

Simply call **866-879-3630 (TTY: 711)** to speak with a friendly, knowledgeable Customer Care specialist, or visit **www.compbenefits.com/custom/stateofflorida/**.

Humana Dental Indemnity with PPO

People First Plan Code #4090
State of Florida

	If you use an in-network dentist		If you use an out-of-network dentist	
Calendar-year deductible	**In-network and out-of-network deductibles** Deductible applies to all services excluding preventive and orthodontia.			
	Employee only $50	Employee + spouse $100	Employee + child(ren) $100	Employee + spouse + child(ren) $150
Calendar-year annual maximum	$2,000		$2,000	
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15)	100% no deductible		100% no deductible	
Basic services • Periodontal cleanings (2 per year) • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, anterior teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment) • Denture repair • Denture relines/rebases (1 every 3 years, following 6 months of denture use)	80% after deductible		80% after deductible	

Humana Dental Indemnity with PPO

People First Plan Code #4090
State of Florida

	If you use an in-network dentist	If you use an out-of-network dentist
Major services • Harmful habit appliances for children (1 per lifetime, through age 14) • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth every 5 years) • Denture adjustments (following 6 months of denture use) • Implants (1 per tooth every 5 years)	50% after deductible	50% after deductible
Orthodontia services	Adult/child orthodontia. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $2,500 lifetime orthodontia maximum.	

	Preventive	Basic	Major	Orthodontia
Waiting periods Enrollment type: Initial enrollment, open enrollment and timely add-on	No	No	No	No

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the out of network fee schedule of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Questions?

Simply call **866-879-3630 (TTY: 711)** to speak with a friendly, knowledgeable Customer Care specialist, or visit **www.compbenefits.com/custom/stateofflorida/**.

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% 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 **www.compbenefits.com/custom/stateofflorida/** 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.

ADA Code	Procedure	
Appointments		**Member cost**
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment) ocedure	$5
D9430	Office visit (normal hours)	no charge
D9440	Office visit (after regularly scheduled hours)	$35
D9986	Missed appointment	$10
D9987	Cancelled appointment	$10
D9999	Emergency visit during regularly scheduled hours, by report	$20

Diagnostic		Member cost
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
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
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
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
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 cost
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
D1510*	Space maintainer – fixed, unilateral (through age 14)	$50
D1516*	Space maintainer – fixed – bilateral, maxillary (through age 14)	$70
D1517*	Space maintainer – fixed – bilateral, mandibular (through age 14)	$70
D1520*	Space maintainer – removable, unilateral (through age 14)	$85
D1526*	Space maintainer – removable – bilateral, maxillary (through age 14)	$90
D1527*	Space maintainer – removable – bilateral, mandibular (through age 14)	$90
D1550	Re-cement or re-bond space maintainer	$10
D1575	Distal shoe space maintainer – fixed unilateral (through age 14; primary teeth only)	$130
Restorative		**Member cost**
D2140	Amalgam – one surface, primary or permanent	$5
D2150	Amalgam – two surfaces, primary or permanent	$5
D2160	Amalgam – three surfaces, primary or permanent	$5
D2161	Amalgam – four or more surfaces, primary or permanent	$5
D2940	Protective restoration	$5
Resin restorative (inlays and onlays limited to one per tooth every five years)		**Member cost**
D2330	Resin based composite – one surface, anterior	$30
D2331	Resin based composite – two surfaces, anterior	$40
D2332	Resin based composite – three surfaces, anterior	$45
D2335	Resin based composite – four or more surfaces or involving incisal angle (anterior)	$65
D2390	Resin based composite crown, anterior	$70
D2391	Resin based composite – one surface, posterior	$45
D2392	Resin based composite – two surfaces, posterior	$55

Resin restorative (cont.)		**Member cost**
D2393	Resin based composite – three surfaces, posterior	$80
D2394	Resin based composite – four or more surfaces, posterior	$90
D2510*	Inlay – metallic, one surface	$225
D2520*	Inlay – metallic, two surfaces	$235
D2530*	Inlay – metallic, three or more surfaces	$245
D2542*	Onlay – metallic, two surfaces	$250
D2543*	Onlay – metallic, three surfaces	$260
D2544*	Onlay – metallic, four or more surfaces	$270
D2610*	Inlay – porcelain/ceramic, one surface	$250
D2620*	Inlay – porcelain/ceramic, two surfaces	$260
D2630*	Inlay – porcelain/ceramic, three or more surfaces	$270
D2642*	Onlay – porcelain/ceramic, two surfaces	$275
D2643*	Onlay – porcelain/ceramic, three surfaces	$285
D2644*	Onlay – porcelain/ceramic, four or more surfaces	$295
D2650*	Inlay – resin based composite, one surface	$225
D2651*	Inlay – resin based composite, two surfaces	$235
D2652*	Inlay – resin based composite, three or more surfaces	$245
D2662*	Onlay – resin based composite, two surfaces	$250
D2663*	Onlay – resin based composite, three surfaces	$260
D2664*	Onlay – resin based composite, four or more surfaces	$270
Crown and bridge (limited to one per tooth every five years)		**Member cost**
D2710*	Crown – resin based composite, indirect	$270
D2712*	Crown – 3/4 resin based composite, indirect	$270
D2720*	Crown – resin with high noble metal	$270
D2721	Crown – resin with predominantly base metal	$270
D2722*	Crown – resin with noble metal	$270
D2740*	Crown – porcelain/ceramic	$270
D2722*	Crown – resin with noble metal	$270
D2750*	Crown – porcelain fused to high noble metal	$270
D2751	Crown – porcelain fused to predominantly base metal	$270
D2752*	Crown – porcelain fused to noble metal	$270
D2780*	Crown – 3/4 cast high noble metal	$270

Crown and bridge (cont.)		**Member cost**
D2781	Crown – 3/4 cast predominantly base metal	$270
D2782*	Crown – 3/4 cast noble metal	$270
D2783*	Crown – 3/4 porcelain/ceramic	$270
D2790*	Crown – full cast high noble metal	$270
D2791	Crown – full cast predominantly base metal	$270
D2792*	Crown – full cast noble metal	$270
D2794*	Crown – titanium	$270
D2799	Provisional crown	no charge
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$15
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	no charge
D2920	Re-cement or re-bond crown	$15
D2929	Crown-Prefabricated porcelain/ceramic crown – primary tooth	$75
D2930	Prefabricated stainless steel crown – primary tooth	$75
D2931	Prefabricated stainless steel crown – permanent tooth	$25
D2932	Prefabricated resin crown	$50
D2933	Prefabricated stainless steel crown with resin window	$50
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	$50
D2950	Core buildup, including any pins	$50
D2951	Pin retention – per tooth, in addition to restoration	$15
D2952*	Cast post and core in addition to crown	$95
D2953*	Each additional cast post – same tooth	$100
D2954	Prefabricated post and core in addition to crown	$85
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post – same tooth, base metal post	$35
D2960	Labial veneer (resin laminate) – chairside	$250
D2961*	Labial veneer (resin laminate) – laboratory	$300
D2962*	Labial veneer (porcelain laminate) – laboratory	$350
D2971	Additional procedure – new crown existing partial denture	$50
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

Crown and bridge (cont.)		**Member cost**
D2983	Veneer repair, necessitated by restorative material failure	no charge
D6940	Stress breaker	$150
D6950	Precision attachment, separate from prosthesis	$195
Prosthodontics – fixed (replacement limited to every five years, adjustments once per year)		**Member cost**
D6210*	Pontic – cast high noble metal	$270
D6211	Pontic – cast predominantly base metal	$270
D6212*	Pontic – cast noble metal	$270
D6240*	Pontic – porcelain fused to high noble metal	$270
D6241	Pontic – porcelain fused to predominantly base metal	$270
D6242*	Pontic – porcelain fused to noble metal	$270
D6750*	Crown – porcelain fused to high noble metal	$270
D6751	Crown – porcelain fused to predominantly base metal	$270
D6752*	Crown – porcelain fused to noble metal	$270
D6790*	Retainer crown – full cast high noble metal	$270
D6791	Retainer crown – full cast predominantly base metal	$270
D6792*	Retainer crown – full cast noble metal	$270
D6794*	Retainer crown – titanium	$270
D6930	Re-cement or re-bond fixed partial denture (per unit)	$15
Prosthodontics (replacement limited to every five years)		**Member cost**
D5110*	Complete denture – maxillary	$375
D5120*	Complete denture – mandibular	$375
D5130*	Immediate denture – maxillary	$375
D5140*	Immediate denture – mandibular	$375
D5211*	Maxillary partial denture-resin base (including retentive/clasping materials, rests and teeth)	$400
D5212*	Mandibular partial denture-resin base (including retentive/clasping materials, rests and teeth)	$400
D5213*	Maxillary partial denture – cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$425
D5214*	Mandibular partial denture – cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$425
D5221	Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	$263
D5222	Immediate mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	$263
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$413

Prosthodontics (cont.)		**Member cost**
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$413
D5225*	Maxillary partial denture – flexible (including clasps, rests and teeth	$425
D5226*	Mandibular partial denture – flexible (including clasps, rests and teeth)	$425
D5282*	Removable unilateral partial denture – one piece metal (including clasps and teeth), maxillary	$350
D5283*	Removable unilateral partial denture – one piece metal (including clasps and teeth), mandibular	$350
D5410	Adjust complete denture – maxillary	$15
D5411	Adjust complete denture – mandibular	$15
D5421	Adjust partial denture – maxillary	$15
D5422	Adjust partial denture – mandibular	$15
D5660*	Add clasp to existing partial denture – per tooth	$90
Endodontics (each procedure limited to once per tooth per life)		**Member cost**
D3110	Pulp cap – direct (excluding final restoration)	$15
D3120	Pulp cap – indirect (excluding final restoration)	$10
D3220	Therapeutic pulpotomy (excluding final restoration)	$40
D3221	Pulpal debridement, primary and permanent teeth (not to be used when root canal is done on the same day)	$85
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$45
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$50
D3310	Root canal therapy – anterior tooth (excluding final restoration)	$110
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$195
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$250
D3331	Treatment of root canal obstruction – non-surgical access	$80
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	$80
D3333	Internal root repair of perforation defects	$90
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$90
D3352	Apexification/recalcification – interim medication replacement (includes any necessary radiographs)	$80
D3353	Apexification/recalcification – final visit (includes any necessary radiographs)	$90
D3410	Apicoectomy – anterior	$135
D3421	Apicoectomy – premolar (first root)	$120
D3425	Apicoectomy – molar (first root)	$120

Endodontics (cont.)		**Member cost**
D3426	Apicoectomy – (each additional root)	$60
D3430	Retrograde filling – per root	$40
D3450	Root amputation – per root (not covered in conjunction with procedure D3920	$95
D3910	Surgical procedure to isolate tooth with rubbed dam	$20
D3920	Hemisection not included in root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
Periodontics – gum treatment		**Member cost**
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$120
D4211	Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$55
D4240	Gingival flap, including root planing – four or more teeth, per quadrant	$150
D4241	Gingival flap, including root planing – one to three teeth, per quadrant	$120
D4245	Apically positioned flap	$175
D4249	Clinical crown lengthening – hard tissue	$150
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$350
D4261	Osseous surgery (including elevation of a full thickness flap and closure) one to three contiguous teeth or tooth bounded spaces per quadrant	$325
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$180
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$95
D4265	Biological materials which can aid soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration – resorbable barrier, per site	$230
D4267	Guided tissue regeneration – non resorbable barrier, per site (includes membrane removal)	$275
D4270	Pedicle soft tissue graft procedure	$260
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$350
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$90
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$265
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

Periodontics – gum treatment (cont.)		**Member cost**
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
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
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
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
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
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
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years)	$50
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
D4910	Periodontal maintenance (covered only after active periodontal therapy)	$45
Repairs to prosthetics		**Member cost**
D5511*	Repair broken complete denture base, mandibular	$35
D5512*	Repair broken complete denture base, maxillary	$35
D5520*	Replace missing or broken teeth – complete denture (each tooth)	$35
D5611*	Repair resin partial denture base, mandibular	$35
D5612*	Repair resin partial denture base, maxillary	$35
D5621*	Repair cast partial framework, mandibular	$35
D5622*	Repair cast partial framework, maxillary	$35
D5630*	Repair or replace broken retentive clasping materials – per tooth	$35
D5640*	Replace broken teeth – per tooth	$35
D5650*	Add tooth to existing partial denture	$35
D5670*	Replace all teeth and acrylic on cast metal framework – maxillary	$210
D5671*	Replace all teeth and acrylic on cast metal framework – mandibular	$225
D5710*	Rebase complete maxillary denture	$200
D5711*	Rebase complete mandibular denture	$200

Repairs to prosthetics (cont.)		**Member cost**
D5720*	Rebase maxillary partial denture	$200
D5721*	Rebase mandibular partial denture	$200
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750*	Reline complete maxillary denture (laboratory)	$95
D5751*	Reline complete mandibular denture (laboratory)	$95
D5760*	Reline maxillary partial denture (laboratory)	$95
D5761*	Reline mandibular partial denture (laboratory)	$95
D5810*	Interim complete denture (maxillary)	$250
D5811*	Interim complete denture (mandibular)	$250
D5820*	Interim partial denture (maxillary)	$80
D5821*	Interim partial denture (mandibular)	$80
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D6214*	Pontic titanium	$270
D6245*	Pontic – porcelain/ceramic	$270
D6250*	Pontic – resin with high noble metal	$270
D6251	Pontic – resin with predominantly base metal	$270
D6252*	Pontic – resin with noble metal	$270
D6253*	Provisional pontic	no charge
D6545*	Retainer – cast metal, resin bonded fixed prosthesis	$250
D6548*	Retainer – porcelain/ceramic, resin bonded fixed prosthesis	$250
D6549*	Resin retainer – for resin bonded fixed prosthesis	$250
D6600*	Retainer inlay – porcelain/ceramic, two surfaces	$270
D6601*	Retainer inlay – porcelain/ceramic, three or more surfaces	$270
D6602*	Retainer inlay – cast high noble metal, two surfaces	$270
D6603*	Retainer inlay – cast high noble metal, three or more surfaces	$270
D6604*	Retainer inlay – cast predominantly base metal, two surfaces	$270
D6605*	Retainer inlay – cast predominantly base metal, three or more surfaces	$270

Repairs to prosthetics (cont.)		**Member cost**
D6606*	Retainer inlay – cast noble metal, two surfaces	$270
D6607*	Retainer inlay – cast noble metal, three or more surfaces	$270
D6608*	Retainer onlay – porcelain/ceramic, two surfaces	$270
D6609*	Retainer onlay – porcelain/ceramic, three or more surfaces	$270
D6610*	Retainer onlay – cast high noble metal, two surfaces	$270
D6611*	Retainer onlay – cast high noble metal, three or more surfaces	$270
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$270
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$270
D6614*	Retainer onlay – cast noble metal, two surfaces	$270
D6615*	Retainer onlay – cast noble metal, three or more surfaces	$270
D6624*	Retainer inlay titanium	$270
D6634*	Retainer onlay titanium	$270
D6710*	Retainer crown – indirect resin based composition	$270
D6720*	Retainer crown – resin with high noble metal	$270
D6721	Retainer crown – resin with predominantly base metal	$270
D6722*	Retainer crown – resin with noble metal	$270
D6740*	Retainer crown – porcelain/ceramic	$280
D6780*	Retainer crown – 3/4 cast high noble metal	$270
D6781	Retainer crown – 3/4 cast predominantly base metal	$270
D6782*	Retainer crown – 3/4 cast noble metal	$270
D6783*	Retainer crown – 3/4 porcelain ceramic, denture	$270
Extractions/oral and maxillofacial surgery		**Member cost**
D7111	Extraction, coronal remnants – primary tooth	no charge
D7140	Removal of impacted tooth – completely bony	no charge
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	Removal of impacted tooth – soft tissue	$55
D7230	Removal of impacted tooth – partially bony	$70
D7240	Removal of impacted tooth – completely bony	$85
D7241	Removal of impacted tooth – completely bony, unusual complications by report	$110
D7250	Surgical removal of residual tooth roots	$40
D7260	Oroantral fistula closure	$350

Extractions/oral and maxillofacial surgery (cont.)		Member cost
D7261	Primary closure of a sinus perforation	$225
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$55
D7280	Exposure of an unerupted tooth (excluding wisdom teeth)	$100
D7282	Mobilization of erupted or malposed tooth to aid eruption	$90
D7285	Incisional biopsy of oral tissue – hard bone, tooth)	$350
D7286	Incisional biopsy of oral tissue – soft (all others)	$120
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy – transepithelial sample collection	$55
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$40
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$75
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$30
D7450	Removal of benign odontogenic cyst or tumor – up to 1.25 cm	$160
D7451	Removal of benign odontogenic cyst or tumor – greater than 1.25 cm	$235
D7471	Removal of lateral exostosis (maxilla or mandible)	$90
D7472	Removal of torus palatinus	$65
D7473	Removal of torus mandibularis	$65
D7485	Reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$35
D7970	Excision hyperplastic tissue – per arch	$85
D7971	Excision of pericoronal gingival	$55
Adjunctive general service		**Member cost**
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$20
D9215	Local anesthesia in conjunction with operative or surgical procedures	no charge
D9222	Deep sedation/general anesthesia – first 15 minutes	$83
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$71
D9230	Inhalation of nitrous oxide analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$83
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$71
D9450	Case presentation, detailed and extensive treatment planning	no charge

Adjunctive general service (cont.)		**Member cost**
D9951	Occlusal adjustment – limited	$35
D9952	Occlusal adjustment – complete	$165
Bleaching		**Member cost**
D9972	External bleaching in office – per arch	$175
D9975	External bleaching in home – per arch	$175
Orthodontics		
NOTE: Members may receive up to a 25% 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 availability 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.

Schedule B Indemnity Plan

People First Plan Code #4084

Schedule of benefits			
Benefit	**Calendar year deductible**	**Calendar year maximum**	**Waiting period**
Type I, II, III	$0 individual $0 family (3 per family)	$1,000 per covered person	None

ADA Code	Procedure	Maximum reimbursement
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 3 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	Extra-oral – 2D projection radiographic image created using a stationary radiation source and detector	$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 reimbursement
TYPE I – Preventive Dental Services (cont.)		
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
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

ADA Code	Procedure	Maximum reimbursement
TYPE II – Basic Dental Services (cont.)		
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]	$62
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

ADA Code	Procedure	Maximum reimbursement
TYPE II – Basic Dental Services (cont.)		
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
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

ADA Code	Procedure	Maximum reimbursement
TYPE II – Basic Dental Services (cont.)		
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 (second epithelialization)	$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		
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

ADA Code	Procedure	Maximum reimbursement
TYPE III – Major Dental Services (cont.)		
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
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

ADA Code	Procedure	Maximum reimbursement
TYPE III – Major Dental Services (cont.)		
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

ADA Code	Procedure	Maximum reimbursement
TYPE III – Major Dental Services (cont.)		
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

[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.

[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.

[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.

[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.

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.

What else comes with your Humana plan?

As a Humana member, you'll have access to other perks like our exclusive discounts on a variety of services that support your overall health and well-being.

Virtual dental care 24/7

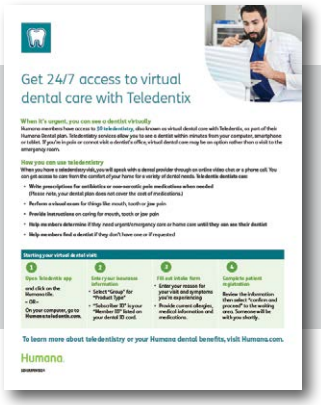
Available with PPO plans only

When it's urgent, you can see a dentist virtually

Humana members have access to $0 teledentistry, also known as virtual dental care, with Teledentix, as part of their Humana Dental plan. Teledentistry services allow you to see a dentist within minutes from your computer, smartphone or tablet.

If you're in pain or cannot visit a dentist's office, virtual dental care may be an option rather than a visit to the emergency room.

To learn more about Humana's virtual dental care, scan the QR code or download the flyer here.


Get 24/7 access to virtual dental care with Teledentix

When it's urgent, you can see a dentist virtually

How you can use teledentistry

Starting your virtual dental visit

To learn more about teledentistry or your Humana dental benefits, visit Humana.com.

Humana.

Exclusive discounts for Humana members

Access to a variety of discounts that support your overall health and well-being

We understand the importance of your overall health and that's why we've carefully selected companies to team up with to offer special discounts Humana members can enjoy:

- **Personalized dental products** for things like invisible teeth straightening aligners, teeth whitening and dental devices with tracking and personalized feedback
- **Vision care discounts** on LASIK, exams, glasses and contacts
- **Hearing aid options** in your area and online
- **Additional discounts** for things like weight loss, massage therapy, fitness devices, and more

Featured dental care programs

To give you something more to smile about, you'll have access to these dental care services:

Byte: Clear aligners you can do from the comfort of your home. **Scan the QR code to learn more.**

Truthbrush: A digital device for kids with oral care tracking technology that attaches to any toothbrush - any brand.

Visit truthbrush.com to learn more.

To learn more about our exclusive discounts available after you enroll in a Humana plan, scan the QR code or download the flyer here.

Manage your plan online

MyCompBenefits: Your dental plan at your fingertips

Once you become a Humana dental plan member, you can register for MyCompBenefits. You'll get quick and secure access to your dental plan information anytime, anywhere:

- Order ID cards
- Check your claims status
- Review deductibles and coverage details

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, gender identity, ancestry, ethnicity, marital status, religion or language. 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 **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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 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 auxillary aids and servces are necessary to ensure an equal opprtunity to participate.

Language assistance services, free of charge, are available to you. 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) اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

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800-939-5369

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Department of MANAGEMENT SERVICES
Division of State Group Insurance

Insured or administered by Humana Insurance Company or offered by CompBenefits Company.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

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