

Deductible	\$0
Annual Maximum	\$2,000
Waiting Periods	None

ADA Code	Description of Benefit	Frequency/Limitations	In Network*	Out of Network**
Exam				
D0120	Periodic oral evaluation – established patient	Two procedure codes per calendar year	100%	50%
Additional exams				
D0150	Comprehensive oral evaluation – new or established patient	One procedure code from this group every three calendar years	100%	50%
D0180	Comprehensive periodontal evaluation – new or established patient		100%	50%
Intraoral X-rays (inside the mouth)				
D0220	Intraoral – periapical first radiographic image	One procedure code from this group per calendar year	100%	50%
D0230	Intraoral – periapical each additional radiographic image		100%	50%
D0240	Intraoral – occlusal radiographic image		100%	50%
Full mouth and panoramic X-rays				
D0210	Intraoral – comprehensive series of radiographic images	One procedure code from this group every five calendar years	100%	50%
D0330	Panoramic radiographic image		100%	50%
Bitewing X-rays				
D0270	Bitewing – single radiographic image	One procedure code from this group per calendar year	100%	50%
D0272	Bitewings – two radiographic images		100%	50%
D0273	Bitewings – three radiographic images		100%	50%
D0274	Bitewings – four radiographic images		100%	50%
Prophylaxis (cleaning)				
D1110	Prophylaxis adult (Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.)	Two procedure codes per calendar year	100%	50%
Anesthesia				
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	As needed with covered codes	100%	50%

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Restorations (fillings)				
D2140	Amalgam – one surface, primary or permanent	Two procedure codes from this group per calendar year	50%	45%
D2150	Amalgam – two surfaces, primary or permanent		50%	45%
D2160	Amalgam – three surfaces, primary or permanent		50%	45%
D2161	Amalgam – four or more surfaces, primary or permanent		50%	45%
D2330	Resin-based composite – one surface, anterior (front)		50%	45%
D2331	Resin-based composite – two surfaces, anterior (front)		50%	45%
D2332	Resin-based composite – three surfaces, anterior (front)		50%	45%
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)		50%	45%
D2391	Resin-based composite – one surface, posterior (back)		50%	45%
D2392	Resin-based composite – two surfaces, posterior (back)		50%	45%
D2393	Resin-based composite – three surfaces, posterior (back)		50%	45%
D2394	Resin-based composite – four or more surfaces, posterior (back)		50%	45%
Extractions				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Unlimited	50%	45%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		50%	45%
Crowns				
D2710	Crown – resin-based composite (indirect)	One procedure code from this group per calendar year	30%	25%
D2712	Crown – 3/4 resin-based composite (indirect)		30%	25%
D2720	Crown – resin with high noble metal		30%	25%
D2721	Crown – resin with predominantly base metal		30%	25%
D2722	Crown – resin with noble metal		30%	25%
D2740	Crown – porcelain/ceramic		30%	25%
D2750	Crown – porcelain fused to high noble metal		30%	25%
D2751	Crown – porcelain fused to predominantly base metal		30%	25%
D2752	Crown – porcelain fused to noble metal		30%	25%

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Crowns (continued)				
D2753	Crown – porcelain fused to titanium and titanium alloys	One procedure code from this group per calendar year	30%	25%
D2780	Crown – 3/4 cast high noble metal		30%	25%
D2781	Crown – 3/4 cast predominantly base metal		30%	25%
D2782	Crown – 3/4 cast noble metal		30%	25%
D2783	Crown – 3/4 porcelain/ceramic		30%	25%
D2790	Crown – full cast high noble metal		30%	25%
D2791	Crown – full cast predominantly base metal		30%	25%
D2792	Crown – full cast noble metal		30%	25%
D2794	Crown – titanium and titanium alloys		30%	25%
Complete dentures (including routine post-delivery care)				
D5110	Complete denture – maxillary	One upper and lower complete denture every five calendar years	30%	25%
D5120	Complete denture – mandibular		30%	25%
D5130	Immediate denture – maxillary		30%	25%
D5140	Immediate denture – mandibular		30%	25%
Removable partial dentures (including routine post-delivery care)				
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	One upper and lower partial denture every five calendar years	30%	25%
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		30%	25%
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		30%	25%
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		30%	25%
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		30%	25%
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		30%	25%
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		30%	25%
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		30%	25%

ADA Code	Description of Benefit	Frequency/Limitations	In Network*	Out of Network**
Removable partial dentures (including routine post-delivery care) (continued)				
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	One upper and lower partial denture every five calendar years	30%	25%
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)		30%	25%
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)		30%	25%
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)		30%	25%
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/ clasping materials, rests and teeth), maxillary		30%	25%
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/ clasping materials, rests and teeth), mandibular		30%	25%
Other removable partial dentures (including routine post-delivery care)				
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/ clasping materials, rests and teeth) – per quadrant	One procedure code per quadrant from this group every five calendar years	30%	25%
D5286	Removable unilateral partial denture – one piece resin (including retentive/ clasping materials, rests and teeth) – per quadrant		30%	25%
Denture adjustments (not covered if within six months of initial placement)				
D5410	Adjust complete denture – maxillary	One procedure code from this group per calendar year	30%	25%
D5411	Adjust complete denture – mandibular		30%	25%
D5421	Adjust partial denture – maxillary		30%	25%
D5422	Adjust partial denture – mandibular		30%	25%
Repairs to dentures				
D5511	Repair broken complete denture base, mandibular	One procedure code from this group per calendar year	30%	25%
D5512	Repair broken complete denture base, maxillary		30%	25%
D5520	Replace missing or broken teeth – complete denture (each tooth)		30%	25%
D5611	Repair resin partial denture base, mandibular		30%	25%
D5612	Repair resin partial denture base, maxillary		30%	25%
D5621	Repair cast partial framework, mandibular		30%	25%
D5622	Repair cast partial framework, maxillary		30%	25%
D5630	Repair or replace broken retentive/ clasping materials – per tooth		30%	25%

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Repairs to dentures (continued)				
D5640	Replace broken teeth – per tooth	One procedure code from this group per calendar year	30%	25%
D5650	Add tooth to existing partial denture		30%	25%
D5660	Add clasp to existing partial denture – per tooth		30%	25%
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		30%	25%
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		30%	25%
Dentures rebase (not covered if within six months of initial placement)				
D5710	Rebase complete maxillary denture	One procedure code from this group per calendar year	30%	25%
D5711	Rebase complete mandibular denture		30%	25%
D5720	Rebase maxillary partial denture		30%	25%
D5721	Rebase mandibular partial denture		30%	25%
D5725	Rebase hybrid prosthesis		30%	25%
Denture reline (not allowed on spare dentures or if within six months of initial placement)				
D5730	Reline complete maxillary denture (direct)	One procedure code from this group per calendar year	30%	25%
D5731	Reline complete mandibular denture (direct)		30%	25%
D5740	Reline maxillary partial denture (direct)		30%	25%
D5741	Reline mandibular partial denture (direct)		30%	25%
D5750	Reline complete maxillary denture (indirect)		30%	25%
D5751	Reline complete mandibular denture (indirect)		30%	25%
D5760	Reline maxillary partial denture (indirect)		30%	25%
D5761	Reline mandibular partial denture (indirect)		30%	25%
D5765	Soft liner for complete or partial removable denture (indirect)		30%	25%
Tissue conditioning (not covered if within six months of initial placement)				
D5850	Tissue conditioning, maxillary	One procedure code from this group per calendar year	30%	25%
D5851	Tissue conditioning, mandibular		30%	25%

**Members:** For information about your dental benefits, call Humana Dental Customer Service at **800-457-4708 (TDD: 711)**, Monday – Friday, 8 a.m. – 6 p.m., in your time zone. Refer to **MyHumana.com** for a full listing of the dental limitations and exclusions available in the Evidence of Coverage (EOC) for your plan. For a copy of this document and other plan resources, please visit **Humana.com/sb**.

**Providers:** For information about dental benefits, call Humana Dental Provider Customer Service **800-833-2223**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

These benefits are offered annually. If they are changed or eliminated next year and have not been used, the member will no longer be eligible for them.

This is an all-inclusive list of covered services under this plan. Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire.

\*In-network dentists have agreed to provide services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

\*\*Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider.

†Humana is a Medicare Advantage preferred provider organization (PPO) plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Dental benefits on this plan use a PPO dental network.

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## 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 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 auxiliary aids and services are necessary to ensure an equal opportunity 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):** Wóda'í beésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

GCHJV5REN 0721

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك