Humana Dental

State of Florida Employees

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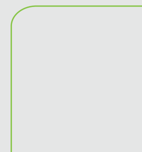

Plans to choose from

- Select 15 Prepaid
- Schedule B Indemnity

Humana®

FLHHB32HH 0717

FILE PREPARED BY HUMANA'S INTERNAL CREATIVE SERVICES | PROOF REVIEW FOR JOB: 105771_FLHHB32HH_Bklt_8.5x11_4C

THE HIVE - CREATIVE SERVICES
JOB: 105771_FLHHB32HH_Bklt_8.5x11_4C
DATE: 07/12/2017
JOB ID: DET

CLIENT: Tammy Hollander
LOB: Group Employer
AGENCY TEAM ASSIGNED
PROD. ART: Dia Thompson
CSL : Kelli Schreiber

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ALL PROJECTS HAVE THREE STANDARD ROUNDS: 1ST-REQUESTOR, 2ND-STAKEHOLDERS, 3RD-CORPORATE REVIEW | FINAL-SIGN-OFF FROM REQUESTOR

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.

Choice of plans

- **Select 15 Prepaid** – a managed care plan
- **Schedule B** – an indemnity plan

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

Your cost in monthly premium

People First Benefit plan code	4044	4084
Dental Plan Name	Select 15 Prepaid	Schedule B 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.

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A dental plan

that will make you smile

How do the plans work?

Select 15 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 Select 15 plan, the participating specialist's fees may be discounted at 25 percent. General dentistry and specialty services are available only in areas where Humana has a participating general dentist and/or specialist.

Schedule B covers preventive care and other dental procedures as listed when you're treated by any dentist you choose. You'll be responsible for deductibles and there are benefit maximums.

Do I have to file a claim form?

Select 15 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: 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?

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

Schedule B: 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 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.

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Select 15 Prepaid plan
People First Plan Code #4044

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Selecting a 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 Select 15 plan, you will need to select a primary care dentist by registering at **www.mycompbenefits.com** or by calling our dedicated Customer Care number at **1-866-879-3630 (TTY: 711)**.

Schedule of benefits

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

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

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Select 15 Prepaid plan
People First Plan Code #4044

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Schedule of benefits

ADA CODE	PROCEDURE	MEMBER PAYS
D2910/D2920/D6930	Recement inlay/onlay/crown/bridge (per unit)	$10

ENDODONTICS

ADA CODE	PROCEDURE	MEMBER PAYS
D3220	Therapeutic pulpotomy	$30

Root Canals

ADA CODE	PROCEDURE	MEMBER PAYS
D3310	Anterior	$100
D3320	Bicuspid	$190
D3330	Molar	$240
D3410	Apicoectomy (anterior only)	$95

PERIODONTICS (gum treatment)

ADA CODE	PROCEDURE	MEMBER PAYS
D4210	Gingivectomy/gingivoplasty – per quadrant	$120
D4211	Gingivectomy/gingivoplasty – per tooth	$36
D4341	Periodontal scaling and root planing – per quadrant	$45
D4342	Scaling and root planing (1 – 3 teeth per quadrant)	$45
D4355	Full mouth debridement	$35
D4381	Localized delivery of chemotherapeutic agents (2 teeth)	$45
D4910	Periodontal maintenance procedures	$45

PROSTHODONTICS

Standard complete dentures (includes adjustments within 30 days)

ADA CODE	PROCEDURE	MEMBER PAYS
D5110	Complete maxillary (upper)	$260
D5120	Complete mandibular (lower)	$260
D5130	Immediate maxillary (upper)	$280
D5140	Immediate mandibular (lower)	$280

Partial dentures (includes adjustments within 30 days)

ADA CODE	PROCEDURE	MEMBER PAYS
D5211/D5212	Maxillary/mandibular partial – resin base (with 2 clasps)	$280
D5213/D5214	Maxillary/mandibular partial – cast metal with resin base (with 2 clasps)	$350
D5410/D5411	Adjust complete – maxillary/mandibular	$15
D5421/D5422	Adjust partial denture – maxillary/mandibular	$15
D5999	Additional clasps, by report	$30

REPAIRS TO PROSTHETICS

ADA CODE	PROCEDURE	MEMBER PAYS
D5510/D5610	Repair broken resin denture base	$15*
D5520/D5640	Replace missing or broken teeth (each tooth)	$10*
D5520/D5640	Each additional tooth	$10*
D5630	Repair or replace broken clasp	$15*
D5650	Add tooth to existing partial denture	$30*
D5850/D5851	Tissue conditioning, maxillary/mandibular	$25
D5730/D5731/D5740/D5741	Relining (chairside)	$45
D5750/D5751/D5760/D5761	Relining (laboratory)	$35*

EXTRACTIONS/ORAL SURGERY

ADA CODE	PROCEDURE	MEMBER PAYS
D7111	Extraction, coronal remnants, primary tooth	NO CHARGE
D7140	Extraction, erupted tooth or exposed root (evaluation and/or forceps removal)	NO CHARGE
D7210	Surgical extraction of erupted tooth	$25
D7220	Soft tissue impaction	$40
D7230	Partially bony impaction	$60
D7240	Completely bony impaction	$75
D7250	Surgical removal of residual tooth roots	$25
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$20
D7311	Alveoloplasty in conjuction with extractions (1-3 teeth or tooth spaces, per quadrant)	$20
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$50
D7321	Alveoloplasty not in conjunction with extractions (1-3 teeth or tooth spaces, per quadrant)	$50

ANESTHESIA

ADA CODE	PROCEDURE	MEMBER PAYS
D9215	Local anesthesia	NO CHARGE
D9230	Analgesia (nitrous oxide - per 15 minutes)	$15

ADJUNCTIVE SERVICES

ADA CODE	PROCEDURE	MEMBER PAYS
D9951	Occlusal adjustment – limited	$25
D9952	Occlusal adjustment – complete	$150

ORTHODONTICS

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

* Plus laboratory fees when applicable.

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

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

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

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Select 15 Prepaid plan
People First Plan Code #4044

SPECIALISTS

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

Limitations and exclusions

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

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

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

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

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

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

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

  g) Treatment for cysts, neoplasms and malignancies.

  h) General anesthesia.

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Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

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

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

[1] Covered twice per 12 consecutive months
[2] Multiple restorations on one surface will be covered as a single filling

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Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2330	Resin-based composite – one surface, anterior[3]	$15.30
D2331	Resin-based composite – two surfaces, anterior[3]	$22.50
D2332	Resin-based composite – three surfaces, anterior[3]	$30.60
D2335	Resin-based composite – four or more surfaces or involving incisal angle[3]	$28.80
D2391	Resin-based composite – one surface, posterior[3]	$11.70
D2392	Resin-based composite – two surfaces, posterior[3]	$18.80
D2393	Resin-based composite – three surfaces, posterior[3]	$22.50
D2394	Resin-based composite – four or more surfaces, posterior[3]	$22.50
D2910	Recement inlay	$11.70
D2920	Recement crown	$11.70
D2940	Sedative filling (Covered as separate procedure if no other service, except X-rays, rendered during the visit)	$12.60
D2950	Core buildup, including any pins	$36.00
D2951	Pin retention – per tooth – in addition to restoration	$17.10
D3220	Therapeutic pulpotomy, excluding final restoration	$20.70
D3310	Root canal therapy – anterior, excluding final restoration	$162.00
D3320	Root canal therapy – bicuspid, excluding final restoration	$198.00
D3330	Root canal therapy – molar, excluding final restoration	$243.00
D3351	Apexification/recalcification – initial visit	$45.90
D3352	Apexification/recalcification – interim medication	$45.90
D3353	Apexification/recalcification – final visit	$45.90
D3410	Apicoectomy/periradicular surgery – anterior	$71.10
D3421	Apicoectomy/periradicular surgery – bicuspid	$71.10
D3425	Apicoectomy/periradicular surgery – molar	$71.10
D3430	Retrograde filling – per tooth	$26.10
D3450	Root amputation – per root	$38.70
D3920	Hemisection (including root removal), not including root canal therapy	$38.70
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth, per quadrant[4]	$51.30
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant[4]	$13.50
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth, per quadrant[4]	$57.60
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant[4]	$57.60
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth, per quadrant	$95.40
D4261	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant	$95.40
D4270	Pedicle soft tissue graft procedure	$57.60
D4271	Free soft tissue graft procedure (including donor site surgery)	$63.90
D4320	Provisional splinting – intracoronal	$18.00
D4321	Provisional splinting – extracoronal	$18.00
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth, per quadrant[5]	$14.40
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant[5]	$14.40
D4355	Full mouth debridement to enable comprehensive eval. and diagnosis[5]	$30.60
D4910	Periodontal maintenance[5]	$19.80
D5510	Repair broken complete denture base[6]	$26.10

[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.

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Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D5520	Replace missing or broken teeth – complete denture[6]	$26.10
D5610	Repair resin denture base[6]	$26.10
D5620	Repair cast framework[6]	$26.10
D5630	Repair or replace broken clasp[6]	$30.60
D5640	Replace broken teeth – per tooth[6]	$18.90
D5650	Add tooth to existing partial denture[6]	$36.00
D5660	Add clasp to existing partial denture[6]	$38.70
D5710	Rebase complete maxillary denture[6]	$76.50
D5711	Rebase complete mandibular denture[6]	$76.50
D5720	Rebase maxillary partial denture[6]	$76.50
D5721	Rebase mandibular partial denture[6]	$76.50
D6930	Recement fixed partial denture.	$16.20
D7111	Coronal remnants, deciduous tooth	$14.40
D7140	Extraction, erupted tooth or exposed root (elev. and/or forceps removal)	$14.40
D7210	Surgical removal of erupted tooth	$26.10
D7220	Removal of impacted tooth – soft tissue	$36.00
D7230	Removal of impacted tooth – partially bony.	$45.90
D7240	Removal of impacted tooth – completely bony	$61.20
D7250	Surgical removal of residual tooth roots	$28.80
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	$47.70
D7272	Tooth transplantation	$51.30
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$21.60
D7311	Alveoloplasty in conjunction with extractions – 1-3 teeth or tooth spaces, per quadrant	$21.60
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$25.20
D7321	Alveoloplasty not in conjunction with extractions – 1-3 teeth or tooth spaces, per quadrant	$25.20
D7340	Vestibuloplasty – ridge extension (second epithelialization)	$38.70
D7350	Vestibuloplasty – ridge extension (incl. tissue procedures)	$76.50

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D7510	Incision and drainage of abscess – intraoral soft tissue.	$22.50
D7520	Incision and drainage of abscess – extraoral soft tissue.	$34.20
D7960	Frenulectomy – separate procedure	$33.30
D7970	Excision of hyperplastic tissue – per arch.	$38.70
D9220	Deep sedation/general anesthesia – first 30 minutes[7]	$30.60
D9610	Therapeutic drug injection	$11.70
D9951	Occlusal adjustment – limited[8]	$14.40
D9952	Occlusal adjustment – Complete[8]	$36.90

TYPE III – MAJOR DENTAL SERVICES

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

[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.

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THE HIVE - CREATIVE SERVICES
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AGENCY TEAM ASSIGNED
PROD. ART: Dia Thompson
CSL : Kelli Schreiber

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ALL PROJECTS HAVE THREE STANDARD ROUNDS: 1ST-REQUESTOR, 2ND-STAKEHOLDERS, 3RD-CORPORATE REVIEW | FINAL-SIGN-OFF FROM REQUESTOR

Schedule B Indemnity plan
People First Plan Code #4084

Schedule of benefits

ADA CODE	PROCEDURE	MAXIMUM REIMBURSEMENT
D2752	Crown – porcelain fused to noble metal (Single restoration only)	$95.40
D2790	Crown – full cast high noble metal (Single restoration only)	$175.50
D2791	Crown – full cast predominantly base metal (Single restoration only)	$82.80
D2792	Crown – full cast noble metal (Single restoration only)	$89.10
D2930	Prefabricated stainless steel crown – primary tooth (Single restoration only)	$21.60
D2931	Prefabricated stainless steel crown – permanent (Single restoration only)	$21.60
D2952	Cast post and core in addition to crown (Single restoration only)	$36.00
D2954	Prefabricated post and core in addition to crown (Single restoration only)	$26.10
D5110	Complete upper denture	$129.60
D5120	Complete lower denture	$129.60
D5130	Immediate upper denture	$135.90
D5140	Immediate lower denture	$135.90
D5211	Upper partial denture – resin base	$79.20
D5212	Lower partial denture – resin base	$79.20
D5213	Upper partial denture – cast metal base with resin saddles	$145.80
D5214	Lower partial denture – cast metal base with resin saddles	$134.10
D5281	Removable unilateral partial denture – one piece cast metal	$28.80
D5410	Adjust complete denture – upper[9]	$8.10
D5411	Adjust complete denture – lower[9]	$8.10
D5421	Adjust partial denture – upper[9]	$8.10
D5422	Adjust partial denture – lower[9]	$8.10
D5730	Reline complete upper denture (chairside)[10]	$32.40
D5731	Reline complete lower denture (chairside)[10]	$32.40
D5740	Reline upper partial denture (chairside)[10]	$26.10
D5741	Reline lower partial denture (chairside)[10]	$26.10
D5750	Reline complete upper denture (laboratory)[10]	$47.70
D5751	Reline complete lower denture (laboratory)[10]	$47.70
D5760	Reline upper partial denture (laboratory)[10]	$41.40
D5761	Reline lower partial denture (laboratory)[10]	$41.40
D6210	Pontic – cast high noble metal	$175.50
D6211	Pontic – cast predominantly base metal	$82.80
D6212	Pontic – cast noble metal	$89.10
D6240	Pontic – porcelain fused to high noble metal	$180.00
D6241	Pontic – porcelain fused to predominately base metal	$91.80
D6242	Pontic – porcelain fused to noble metal	$95.40
D6250	Pontic – resin with high noble metal	$98.10
D6251	Pontic – resin with predominately base metal	$85.50
D6252	Pontic – resin with noble metal	$89.10
D6602	Inlay – cast high noble metal, two surfaces[11]	$79.20
D6603	Inlay – cast high noble metal, three or more surfaces[11]	$85.50
D6604	Inlay – cast predominantly base metal two surfaces[11]	$79.20
D6605	Inlay – cast predominantly base metal three or more surfaces[11]	$85.50
D6606	Inlay – cast noble metal, two surfaces[11]	$79.20
D6607	Inlay – cast noble metal, three or more surfaces[11]	$85.50
D6720	Crown – resin with high noble metal[11]	$98.10
D6721	Crown – resin with predominately base metal[11]	$85.50
D6722	Crown – resin with noble metal[11]	$89.10
D6750	Crown – porcelain fused to high noble metal[11]	$180.00
D6751	Crown – porcelain fused to predominantly base metal[11]	$91.80
D6752	Crown – porcelain fused to noble metal[11]	$95.40
D6780	Crown – 3/4 cast high noble metal[11]	$91.80
D6790	Crown – full cast high noble metal[11]	$175.50
D6791	Crown – full cast predominately base metal[11]	$85.50
D6792	Crown – full cast noble metal[11]	$89.10

[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.

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LoRes7

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PROOF ROUND
R1

4C
ALL PROJECTS HAVE THREE STANDARD ROUNDS: 1ST-REQUESTOR, 2ND-STAKEHOLDERS, 3RD-CORPORATE REVIEW | FINAL-SIGN-OFF FROM REQUESTOR

Schedule B Indemnity plan
People First Plan Code #4084

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

ZERes7

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PROOF ROUND
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4C ALL PROJECTS HAVE THREE STANDARD ROUNDS: 1ST-REQUESTOR, 2ND-STAKEHOLDERS, 3RD-CORPORATE REVIEW | FINAL-SIGN-OFF FROM REQUESTOR

Discrimination is against the law

Humana Inc. and its subsidiaries comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235** or if you use a TTY, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with 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.**

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**.... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-320-1235 (TTY: 711)** 。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-320-1235 (TTY: 711)**.... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-320-1235 (TTY: 711)**번으로 전화해 주십시오.... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-320-1235 (TTY: 711)**.... Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-320-1235 (телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-320-1235 (TTY: 711)**.... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-320-1235 (ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-320-1235 (TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-320-1235 (TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-320-1235 (TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-320-1235 (TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-320-1235 (TTY: 711)**まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **(TTY: 711)1-877-320-1235** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, kojį' hódíílnih **1-877-320-1235 (TTY: 711)**....

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235** (رقم هاتف الصم والبكم: **711**).

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

FLHHB32HH 0717

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