2027 DEN287

HumanaDental Medicare Network

The following provides an all-inclusive list of dental services covered under this plan. Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. 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 annual maximum benefit coverage amount. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

Contact Information

Members: For information about your dental benefits, call Humana Dental Customer Service at **800-457-4708 (TTY: 711)**, Monday – Friday, 8 a.m. to 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 at **800-833-2223**, Monday – Friday, 8 a.m. to 8 p.m., Eastern time.

Additional Plan Details

- In-network dental providers have agreed to provide covered services at contracted rates per the in-network fee schedules (INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings. The provider locator for our nationwide network can be found at **Humana.com/FindCare**.
- Out-of-network dental providers have not agreed to provide services at contracted fees. **The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing.** Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, the member may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in the member's area.
- Humana is a Medicare Advantage PPO organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. Dental benefits on this plan use a nationwide PPO dental network.

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Deductible	$0
Annual maximum	$2,000
Waiting periods	None

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Exam				
D0120	Periodic oral evaluation – established patient	Two procedure codes per calendar year	100%	100%
Emergency diagnostic exam				
D0140	Limited oral evaluation – problem focused	Two procedure codes per calendar year	100%	100%
Additional exams				
D0150	Comprehensive oral evaluation – new or established patient	One procedure code from this group every three calendar years	100%	100%
D0180	Comprehensive periodontal evaluation – new or established patient		100%	100%
Full mouth and panoramic X-rays				
D0210	Intraoral – comprehensive series of radiographic images	One procedure code from this group every five calendar years	100%	100%
D0330	Panoramic radiographic image		100%	100%
Intraoral X-rays (inside the mouth)				
D0220	Intraoral – periapical first radiographic image	Six procedure codes from this group per calendar year	100%	100%
D0230	Intraoral – periapical each additional radiographic image		100%	100%
Bitewing X-rays				
D0270	Bitewing – single radiographic image	One procedure code from this group per calendar year	100%	100%
D0272	Bitewings – two radiographic images		100%	100%
D0273	Bitewings – three radiographic images		100%	100%
D0274	Bitewings – four radiographic images		100%	100%
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%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Restorations (fillings)				
D2140	Amalgam – one surface, primary or permanent	One procedure code per tooth per surface from this group every two calendar years	100%	100%
D2150	Amalgam – two surfaces, primary or permanent		100%	100%
D2160	Amalgam – three surfaces, primary or permanent		100%	100%
D2161	Amalgam – four or more surfaces, primary or permanent		100%	100%
D2330	Resin-based composite – one surface, anterior (front)		100%	100%
D2331	Resin-based composite – two surfaces, anterior (front)		100%	100%
D2332	Resin-based composite – three surfaces, anterior (front)		100%	100%
D2335	Resin-based composite – four or more surfaces (anterior)		100%	100%
D2391	Resin-based composite – one surface, posterior (back)		100%	100%
D2392	Resin-based composite – two surfaces, posterior (back)		100%	100%
D2393	Resin-based composite – three surfaces, posterior (back)		100%	100%
D2394	Resin-based composite – four or more surfaces, posterior (back)		100%	100%
Crowns				
D2542	Onlay – metallic – two surfaces	One procedure code per tooth from this group every five calendar years	100%	100%
D2543	Onlay – metallic – three surfaces		100%	100%
D2544	Onlay – metallic – four or more surfaces		100%	100%
D2642	Onlay – porcelain/ceramic – two surfaces		100%	100%
D2643	Onlay – porcelain/ceramic – three surfaces		100%	100%
D2644	Onlay – porcelain/ceramic – four or more surfaces		100%	100%
D2662	Onlay – resin-based composite – two surfaces		100%	100%
D2663	Onlay – resin-based composite – three surfaces		100%	100%
D2664	Onlay – resin-based composite – four or more surfaces		100%	100%
D2710	Crown – resin-based composite (indirect)		100%	100%
D2712	Crown – 3/4 resin-based composite (indirect)		100%	100%
D2720	Crown – resin with high noble metal		100%	100%
D2721	Crown – resin with predominantly base metal		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Crowns (continued)				
D2722	Crown – resin with noble metal	One procedure code per tooth from this group every five calendar years	100%	100%
D2740	Crown – porcelain/ceramic		100%	100%
D2750	Crown – porcelain fused to high noble metal		100%	100%
D2751	Crown – porcelain fused to predominantly base metal		100%	100%
D2752	Crown – porcelain fused to noble metal		100%	100%
D2753	Crown – porcelain fused to titanium and titanium alloys		100%	100%
D2780	Crown – 3/4 cast high noble metal		100%	100%
D2781	Crown – 3/4 cast predominantly base metal		100%	100%
D2782	Crown – 3/4 cast noble metal		100%	100%
D2783	Crown – 3/4 porcelain/ceramic		100%	100%
D2790	Crown – full cast high noble metal		100%	100%
D2791	Crown – full cast predominantly base metal		100%	100%
D2792	Crown – full cast noble metal		100%	100%
D2794	Crown – titanium and titanium alloys		100%	100%
Re-cement of crown				
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	One procedure code from this group every two calendar years	100%	100%
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		100%	100%
D2920	Re-cement or re-bond crown		100%	100%
Restorative (other services) core buildup or prefabricated post and core				
D2950	Core buildup, including any pins when required	One procedure code per tooth from this group every five calendar years	100%	100%
D2952	Post and core in addition to crown, indirectly fabricated		100%	100%
D2953	Each additional indirectly fabricated post – same tooth		100%	100%
D2954	Prefabricated post and core in addition to crown		100%	100%
D2957	Each additional prefabricated post – same tooth		100%	100%
Endodontic services				
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	One procedure code per tooth from this group per lifetime	100%	100%
D3320	Endodontic therapy, premolar tooth (excluding final restoration)		100%	100%
D3330	Endodontic therapy, molar tooth (excluding final restoration)		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Endodontic retreatment				
D3346	Retreatment of previous root canal therapy – anterior	One procedure code per tooth from this group per lifetime	100%	100%
D3347	Retreatment of previous root canal therapy – premolar		100%	100%
D3348	Retreatment of previous root canal therapy – molar		100%	100%
Periodontal scaling and root planing				
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	One procedure code per quadrant from this group every three calendar years	100%	100%
D4342	Periodontal scaling and root planing – one to three teeth per quadrant		100%	100%
Scaling – moderate gingival inflammation				
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	One procedure code per calendar year	100%	100%
Periodontal maintenance				
D4910	Periodontal maintenance	Four procedure codes per calendar year	100%	100%
Complete dentures (including routine post-delivery care)				
D5110	Complete denture – maxillary	One upper and lower complete or one upper and lower immediate denture every five calendar years	100%	100%
D5120	Complete denture – mandibular		100%	100%
D5130	Immediate denture – maxillary		100%	100%
D5140	Immediate denture – mandibular		100%	100%
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	100%	100%
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		100%	100%
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		100%	100%
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		100%	100%
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		100%	100%
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Removable partial dentures (including routine post-delivery care) (continued)				
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	One upper and lower partial denture every five calendar years	100%	100%
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		100%	100%
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)		100%	100%
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)		100%	100%
D5227	Immediate Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)		100%	100%
D5228	Immediate Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)		100%	100%
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary		100%	100%
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular		100%	100%
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	100%	100%
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant		100%	100%
Denture adjustments (not covered if within six months of initial placement)				
D5410	Adjust complete denture – maxillary	Two procedure codes from this group per calendar year	100%	100%
D5411	Adjust complete denture – mandibular		100%	100%
D5421	Adjust partial denture – maxillary		100%	100%
D5422	Adjust partial denture – mandibular		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Repairs to dentures (not covered if within six months of initial placement)				
D5511	Repair complete denture base, mandibular	One upper procedure code and one lower procedure code from this group per calendar year	100%	100%
D5512	Repair complete denture base, maxillary		100%	100%
D5521	Replace all teeth on complete denture – maxillary		100%	100%
D5522	Replace all teeth on complete denture – mandibular		100%	100%
D5611	Repair resin partial denture base, mandibular		100%	100%
D5612	Repair resin partial denture base, maxillary		100%	100%
D5621	Repair cast partial framework, mandibular		100%	100%
D5622	Repair cast partial framework, maxillary		100%	100%
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		100%	100%
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		100%	100%
D5520	Replace missing or broken teeth – complete denture – per tooth	Two procedure codes per tooth from this group per calendar year	100%	100%
D5630	Repair or replace broken retentive/clasping materials – per tooth		100%	100%
D5640	Replace missing or broken teeth – partial denture – per tooth		100%	100%
D5650	Add tooth to existing partial denture – per tooth	One procedure code per tooth from this group every five calendar years	100%	100%
D5660	Add clasp to existing partial denture – per tooth		100%	100%
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	100%	100%
D5711	Rebase complete mandibular denture		100%	100%
D5720	Rebase maxillary partial denture		100%	100%
D5721	Rebase mandibular partial denture		100%	100%
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	100%	100%
D5731	Reline complete mandibular denture (direct)		100%	100%
D5740	Reline maxillary partial denture (direct)		100%	100%
D5741	Reline mandibular partial denture (direct)		100%	100%
D5750	Reline complete maxillary denture (indirect)		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Denture reline (not allowed on spare dentures or if within six months of initial placement) (continued)				
D5751	Reline complete mandibular denture (indirect)	One procedure code from this group per calendar year	100%	100%
D5760	Reline maxillary partial denture (indirect)		100%	100%
D5761	Reline mandibular partial denture (indirect)		100%	100%
Tissue conditioning (not covered if within six months of initial placement)				
D5850	Tissue conditioning, maxillary	One procedure code from this group per calendar year	100%	100%
D5851	Tissue conditioning, mandibular		100%	100%
Extractions				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	One procedure code per tooth per lifetime	100%	100%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	One procedure code per tooth per lifetime	100%	100%
D7220	Removal of impacted tooth – soft tissue	One procedure code per tooth per lifetime	100%	100%
D7230	Removal of impacted tooth – partially bony	One procedure code per tooth per lifetime	100%	100%
D7240	Removal of impacted tooth – completely bony	One procedure code per tooth per lifetime	100%	100%
D7250	Removal of residual tooth roots (cutting procedure)	One procedure code per tooth per lifetime	100%	100%
Oral surgery				
D7284	Excisional biopsy of minor salivary glands	Two procedure codes from this group per calendar year	100%	100%
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)		100%	100%
D7286	Incisional biopsy of oral tissue – soft		100%	100%
D7287	Exfoliative cytological sample collection		100%	100%
D7288	Brush biopsy – transepithelial sample collection		100%	100%
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		100%	100%
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		100%	100%
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		100%	100%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Oral surgery (continued)				
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Two procedure codes from this group per calendar year	100%	100%
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		100%	100%
D7509	Marsupialization of odontogenic cyst		100%	100%
D7510	Incision and drainage of abscess – intraoral soft tissue		100%	100%
D7961	Buccal/labial frenectomy (frenulectomy)		100%	100%
D7962	Lingual frenectomy (frenulectomy)		100%	100%
D7963	Frenuloplasty		100%	100%
Pain management				
D9110	Palliative treatment of dental pain – per visit	Two procedure codes per calendar year	100%	100%
Anesthesia – general (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)				
D9222	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	Two procedure codes from this group per calendar year	100%	100%
D9239	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof		100%	100%
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof		100%	100%
Anesthesia – incremental (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)				
D9223	Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	As needed with covered codes	100%	100%
D9243	Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof		100%	100%
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof		100%	100%
Anesthesia – nitrous oxide/analgesia (in conjunction with covered services, subject to plan limitations and exclusions, subject to clinical review)				
D9230	Administration of nitrous oxide	One unit per visit – only covered if primary procedure is covered	100%	100%
Occlusal adjustments (not covered if within six months of initial placement)				
D9951	Occlusal adjustment – limited	One procedure code every three calendar years	100%	100%

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Dental Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).
- Initial placement or replacement of a prior denture that is unserviceable and cannot be made serviceable. Spare dentures are not covered.
- Dental reline may not be covered within six months of initial denture placement or on spare dentures.
- Dental adjustments may not be covered within six months of initial denture placement or on spare dentures.
- Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
    - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
    - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures to include, but are not limited to:
    - Facings on crowns or pontics – the portion of a fixed bridge between the abutments – posterior to the second bicuspid;
    - Any service to correct congenital malformation;
    - Any service performed primarily to improve appearance;
    - Characterizations and personalization of prosthetic devices; or
    - Any procedure to change the spacing and/or shape of the teeth.
- Charges for:
    - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
    - Precision or semi-precision attachments;
    - Other customized attachments;
    - Temporary or interim dental services;
    - Additional charges related to material or equipment used in the delivery of dental care;
    - The removal of any implants unless a covered service.
- Any service related to:
    - Altering vertical dimension of teeth.
    - Restoration or maintenance of occlusion.
    - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
    - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
    - Bite registration or bite analysis.
    - Bone grafting at site(s) of which documentation does not support future restoration.
- Infection control, including but not limited to sterilization techniques.
- Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in the Coverage Information.
- Any service that is not eligible for benefits based upon clinical review; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Orthodontic services.
- Retainer Crown services when bridge coverage is not included in the benefit.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the reimbursement limit for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models/diagnostic casts, treatment plans, occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- When the primary service(s) is denied all associated service(s) in conjunction with it are additionally denied.
- Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy. A separate fee for these services is not considered a covered expense.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
    - Any services for orthognathic surgery;
    - Any services for destruction of lesions by any method;
    - Any services for tooth transplantation;
    - Any services for removal of a foreign body from the oral tissue or bone;
    - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
    - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
    - Pain control unless a documented allergy to local anesthetic is provided;
    - Anxiety;
    - Fear of pain;
    - Pain management;
    - Emotional inability to undergo surgery.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the Coverage Information.

- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.