

2025 DEN351

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 dental coverage limit. 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).
- Out-of-network dental providers 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. 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.
- **When visiting an out-of-network dental provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.**
- Humana is a Medicare Advantage preferred provider organization (PPO) with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. Dental benefits on this plan use a PPO dental network.

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|-----------------|---------|
| Deductible | \$0 |
| Annual maximum | \$1,000 |
| 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 every calendar year | 100% | 100% |
| Emergency diagnostic exam | | | | |
| D0140 | Limited oral evaluation – problem focused | One procedure code every 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% |
| Intraoral X-rays (inside the mouth) | | | | |
| D0220 | Intraoral – periapical first radiographic image | One procedure code from this group per calendar year | 100% | 100% |
| D0230 | Intraoral – periapical each additional radiographic image | | 100% | 100% |
| D0240 | Intraoral – occlusal radiographic image | | 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% |
| Bitewing X-rays | | | | |
| D0270 | Bitewing – single radiographic image | One procedure code from this group every 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 every calendar year | 100% | 100% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|---|---------------------------------|---------------------------------|
| Anesthesia (subject to plan limitations and exclusions) | | | | |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | As needed with covered codes | 100% | 100% |
| Restorations (fillings) | | | | |
| D2140 | Amalgam – one surface, primary or permanent | Two procedure codes from this group per calendar year | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2150 | Amalgam – two surfaces, primary or permanent | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2160 | Amalgam – three surfaces, primary or permanent | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2161 | Amalgam – four or more surfaces, primary or permanent | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2330 | Resin-based composite – one surface, anterior (front) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2331 | Resin-based composite – two surfaces, anterior (front) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2332 | Resin-based composite – three surfaces, anterior (front) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2335 | Resin-based composite – four or more surfaces (anterior) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2391 | Resin-based composite – one surface, posterior (back) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2392 | Resin-based composite – two surfaces, posterior (back) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2393 | Resin-based composite – three surfaces, posterior (back) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| D2394 | Resin-based composite – four or more surfaces, posterior (back) | | 100% after \$25 copay per tooth | 100% after \$25 copay per tooth |
| Periodontal maintenance | | | | |
| D4910 | Periodontal maintenance | Four procedure codes every calendar year | 100% | 100% |

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