2026 DEN620

Florida GoldPlus Dental 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). The provider locator for our nationwide network can be found at **Humana.com/FindCare**.
- No out-of-network coverage on this plan.
- Humana is a Medicare Advantage health maintenance organization (HMO) with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. Dental benefits on this plan use a preferred provider organization (PPO) dental network.

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Deductible	$0
Annual maximum	$1,500
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%	0%
Emergency diagnostic exam				
D0140	Limited oral evaluation – problem focused	One procedure code per calendar year	100%	0%
Additional exams				
D0150	Comprehensive oral evaluation – new or established patient	One procedure code from this group every three calendar years	100%	0%
D0180	Comprehensive periodontal evaluation – new or established patient		100%	0%
Intraoral X-rays (inside the mouth)				
D0220	Intraoral – periapical first radiographic image	One procedure code from this group per calendar year	100%	0%
D0230	Intraoral – periapical each additional radiographic image		100%	0%
Full mouth and panoramic X-rays				
D0210	Intraoral – comprehensive series of radiographic images	One procedure code from this group every five calendar years	100%	0%
D0330	Panoramic radiographic image		100%	0%
Bitewing X-rays				
D0270	Bitewing – single radiographic image	One procedure code from this group per calendar year	100%	0%
D0272	Bitewings – two radiographic images		100%	0%
D0273	Bitewings – three radiographic images		100%	0%
D0274	Bitewings – four radiographic images		100%	0%
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%	0%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Anesthesia – nitrous oxide/analgesia (in conjunction with covered services, subject to plan limitations and exclusions, subject to clinical review)				
D9230	Administration of nitrous oxide	As needed with covered codes	100%	0%
Restorations (fillings)				
D2140	Amalgam – one surface, primary or permanent	Two procedure codes from this group per calendar year	100% after $25 copay per tooth	0%
D2150	Amalgam – two surfaces, primary or permanent		100% after $25 copay per tooth	0%
D2160	Amalgam – three surfaces, primary or permanent		100% after $25 copay per tooth	0%
D2161	Amalgam – four or more surfaces, primary or permanent		100% after $25 copay per tooth	0%
D2330	Resin-based composite – one surface, anterior (front)		100% after $25 copay per tooth	0%
D2331	Resin-based composite – two surfaces, anterior (front)		100% after $25 copay per tooth	0%
D2332	Resin-based composite – three surfaces, anterior (front)		100% after $25 copay per tooth	0%
D2335	Resin-based composite – four or more surfaces (anterior)		100% after $25 copay per tooth	0%
D2391	Resin-based composite – one surface, posterior (back)		100% after $25 copay per tooth	0%
D2392	Resin-based composite – two surfaces, posterior (back)		100% after $25 copay per tooth	0%
D2393	Resin-based composite – three surfaces, posterior (back)		100% after $25 copay per tooth	0%
D2394	Resin-based composite – four or more surfaces, posterior (back)		100% after $25 copay per tooth	0%
Periodontal maintenance				
D4910	Periodontal maintenance	Four procedure codes per calendar year	100%	0%

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).
- Services received from an out-of-network dentist are not covered benefits.
- 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 loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- 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.
- 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.
- 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.