

2026 DEN714

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). 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.



2026 DEN714

HumanaDental® Medicare Network

| | |
|-----------------|------|
| Deductible | \$0 |
| Annual maximum | None |
| 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% |
| D0160 | Detailed and extensive oral evaluation – problem focused, by report | | 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% |
| D0240 | Intraoral – occlusal 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% |
| D0250 | Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector | | 100% | 0% |
| D0251 | Extra-oral posterior dental radiographic image | | 100% | 0% |
| D0310 | Sialography | | 100% | 0% |
| D0320 | Temporomandibular joint arthrogram, including injection | | 100% | 0% |
| D0321 | Other temporomandibular joint radiographic images, by report | | 100% | 0% |
| D0330 | Panoramic radiographic image | | 100% | 0% |
| D0340 | 2D cephalometric radiographic image – acquisition, measurement and analysis | | 100% | 0% |
| D0350 | 2D oral/facial photographic image obtained intra-orally or extra-orally | | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|--|---|---------------------|-------------------------|
| 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% |
| Fluoride | | | | |
| D1206 | Topical application of fluoride varnish | Two procedure codes from this group per calendar year | 100% | 0% |
| D1208 | Topical application of fluoride – excluding varnish | | 100% | 0% |
| 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 | As needed with covered codes | 100% | 0% |
| D9223 | Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| D9239 | Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof | | 100% | 0% |
| D9243 | Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| D9246 | Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof | | 100% | 0% |
| D9247 | Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof | | 100% | 0% |
| Restorations (fillings) | | | | |
| D2140 | Amalgam – one surface, primary or permanent | Unlimited | 100% | 0% |
| D2150 | Amalgam – two surfaces, primary or permanent | | 100% | 0% |
| D2160 | Amalgam – three surfaces, primary or permanent | | 100% | 0% |
| D2161 | Amalgam – four or more surfaces, primary or permanent | | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|--|---|---|---------------------|-------------------------|
| Restorations (fillings) (continued) | | | | |
| D2330 | Resin-based composite – one surface, anterior (front) | Unlimited | 100% | 0% |
| D2331 | Resin-based composite – two surfaces, anterior (front) | | 100% | 0% |
| D2332 | Resin-based composite – three surfaces, anterior (front) | | 100% | 0% |
| D2335 | Resin-based composite – four or more surfaces (anterior) | | 100% | 0% |
| D2390 | Resin-based composite crown, anterior | | 100% | 0% |
| D2391 | Resin-based composite – one surface, posterior (back) | | 100% | 0% |
| D2392 | Resin-based composite – two surfaces, posterior (back) | | 100% | 0% |
| D2393 | Resin-based composite – three surfaces, posterior (back) | | 100% | 0% |
| D2394 | Resin-based composite – four or more surfaces, posterior (back) | | 100% | 0% |
| Extractions | | | | |
| D7111 | Extraction, coronal remnants – primary tooth | Unlimited | 100% | 0% |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | | 100% | 0% |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | | 100% | 0% |
| Oral surgery | | | | |
| D7220 | Removal of impacted tooth – soft tissue | Two procedure codes from this group per calendar year | 100% | 0% |
| D7230 | Removal of impacted tooth – partially bony | | 100% | 0% |
| D7240 | Removal of impacted tooth – completely bony | | 100% | 0% |
| D7241 | Removal of impacted tooth – completely bony, with unusual surgical complications | | 100% | 0% |
| D7250 | Removal of residual tooth roots (cutting procedure) | | 100% | 0% |
| Crowns | | | | |
| D2710 | Crown – resin-based composite (indirect) | One per tooth per lifetime | 100% | 0% |
| D2712 | Crown – 3/4 resin-based composite (indirect) | | 100% | 0% |
| D2720 | Crown – resin with high noble metal | | 100% | 0% |
| D2721 | Crown – resin with predominantly base metal | | 100% | 0% |
| D2722 | Crown – resin with noble metal | | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|---|---|--|---------------------|-------------------------|
| Crowns (continued) | | | | |
| D2740 | Crown – porcelain/ceramic | One per tooth per lifetime | 100% | 0% |
| D2750 | Crown – porcelain fused to high noble metal | | 100% | 0% |
| D2751 | Crown – porcelain fused to predominantly base metal | | 100% | 0% |
| D2752 | Crown – porcelain fused to noble metal | | 100% | 0% |
| D2753 | Crown – porcelain fused to titanium and titanium alloys | | 100% | 0% |
| D2780 | Crown – 3/4 cast high noble metal | | 100% | 0% |
| D2781 | Crown – 3/4 cast predominantly base metal | | 100% | 0% |
| D2782 | Crown – 3/4 cast noble metal | | 100% | 0% |
| D2783 | Crown – 3/4 porcelain/ceramic | | 100% | 0% |
| D2790 | Crown – full cast high noble metal | | 100% | 0% |
| D2791 | Crown – full cast predominantly base metal | | 100% | 0% |
| D2792 | Crown – full cast noble metal | | 100% | 0% |
| D2794 | Crown – titanium and titanium alloys | | 100% | 0% |
| Re-cement of crown | | | | |
| D2920 | Re-cement or re-bond crown | One procedure code every five calendar years | 100% | 0% |
| Restorative (other services) core buildup or prefabricated post and core | | | | |
| D2930 | Prefabricated stainless steel crown – primary Tooth | One per tooth per lifetime | 100% | 0% |
| D2931 | Prefabricated stainless steel crown – permanent tooth | | 100% | 0% |
| D2932 | Prefabricated resin crown | | 100% | 0% |
| D2933 | Prefabricated stainless steel crown with resin window | | 100% | 0% |
| D2934 | Prefabricated esthetic coated stainless steel crown – primary tooth | | 100% | 0% |
| D2951 | Pin retention – per tooth, in addition to restoration | | 100% | 0% |
| D2952 | Post and core in addition to crown, indirectly fabricated | | 100% | 0% |
| D2954 | Prefabricated post and core in addition to crown | | 100% | 0% |
| D2955 | Post removal | | 100% | 0% |
| D2980 | Crown repair necessitated by restorative material failure | | 100% | 0% |
| D2999 | Unspecified restorative procedure, by report | | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|--|--|---|---------------------|-------------------------|
| Endodontic services | | | | |
| D3230 | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) | One per tooth per lifetime | 100% | 0% |
| D3240 | Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) | | 100% | 0% |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | | 100% | 0% |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | | 100% | 0% |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | | 100% | 0% |
| Endodontic retreatment | | | | |
| D3346 | Retreatment of previous root canal therapy – anterior | One per tooth per lifetime | 100% | 0% |
| D3347 | Retreatment of previous root canal therapy – premolar | | 100% | 0% |
| D3348 | Retreatment of previous root canal therapy – molar | | 100% | 0% |
| Complete dentures (including routine post-delivery care) | | | | |
| D5110 | Complete denture – maxillary | One upper and lower complete denture every eight calendar years | 100% | 0% |
| D5120 | Complete denture – mandibular | | 100% | 0% |
| 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 eight calendar years | 100% | 0% |
| D5212 | Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5225 | Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth) | | 100% | 0% |
| D5226 | Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth) | | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|--|---|--|---------------------|-------------------------|
| 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 | 100% | 0% |
| D5411 | Adjust complete denture – mandibular | | 100% | 0% |
| D5421 | Adjust partial denture – maxillary | | 100% | 0% |
| D5422 | Adjust partial denture – mandibular | | 100% | 0% |
| Repairs to dentures (not covered if within six months of initial placement) | | | | |
| D5511 | Repair broken complete denture base, mandibular | One procedure code from this group per calendar year | 100% | 0% |
| D5512 | Repair broken complete denture base, maxillary | | 100% | 0% |
| D5520 | Replace missing or broken teeth – complete denture – per tooth | | 100% | 0% |
| D5611 | Repair resin partial denture base, mandibular | | 100% | 0% |
| D5612 | Repair resin partial denture base, maxillary | | 100% | 0% |
| D5621 | Repair cast partial framework, mandibular | | 100% | 0% |
| D5622 | Repair cast partial framework, maxillary | | 100% | 0% |
| D5630 | Repair or replace broken retentive/clasping materials – per tooth | | 100% | 0% |
| D5640 | Replace missing or broken teeth – partial denture – per tooth | | 100% | 0% |
| D5650 | Add tooth to existing partial denture – per tooth | | 100% | 0% |
| D5660 | Add clasp to existing partial denture – per tooth | | 100% | 0% |
| 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% | 0% |
| D5711 | Rebase complete mandibular denture | | 100% | 0% |
| D5720 | Rebase maxillary partial denture | | 100% | 0% |
| D5721 | Rebase mandibular partial denture | | 100% | 0% |
| 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% | 0% |
| D5731 | Reline complete mandibular denture (direct) | | 100% | 0% |
| D5740 | Reline maxillary partial denture (direct) | | 100% | 0% |
| D5741 | Reline mandibular partial denture (direct) | | 100% | 0% |
| D5750 | Reline complete maxillary denture (indirect) | | 100% | 0% |
| D5751 | Reline complete mandibular denture (indirect) | | 100% | 0% |

| 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) | | | | |
| D5760 | Reline maxillary partial denture (indirect) | One procedure code from this group per calendar year | 100% | 0% |
| D5761 | Reline mandibular partial denture (indirect) | | 100% | 0% |
| 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% | 0% |
| D5851 | Tissue conditioning, mandibular | | 100% | 0% |
| Implants | | | | |
| D6010 | Surgical placement of implant body: endosteal implant | One per tooth per lifetime | 100% | 0% |
| D6100 | Surgical removal of implant body | One per tooth per lifetime | 100% | 0% |
| D6101 | Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure | One per tooth per lifetime | 100% | 0% |
| D6102 | Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure | One per tooth per lifetime | 100% | 0% |
| D6103 | Bone graft for repair of peri-implant defect – does not include flap entry and closure | One per tooth per lifetime | 100% | 0% |
| D6104 | Bone graft at time of implant placement | One per tooth per lifetime | 100% | 0% |
| D6049 | Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure | One per calendar year | 100% | 0% |
| D6055 | Connecting bar – implant supported or abutment supported | One per tooth per lifetime Subject to review, clinical necessity and frequencies | 100% | 0% |
| D6056 | Prefabricated abutment – includes modification and placement | One per tooth per lifetime | 100% | 0% |
| D6057 | Custom fabricated abutment – includes placement | One per tooth per lifetime | 100% | 0% |
| D6058 | Abutment supported porcelain/ceramic crown | One per tooth per lifetime | 100% | 0% |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | One per tooth per lifetime | 100% | 0% |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | One per tooth per lifetime | 100% | 0% |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | One per tooth per lifetime | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|-----------------|--|--|---------------------|-------------------------|
| Implants | | | | |
| D6062 | Abutment supported cast metal crown (high noble metal) | One per tooth per lifetime | 100% | 0% |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | One per tooth per lifetime | 100% | 0% |
| D6064 | Abutment supported cast metal crown (noble metal) | One per tooth per lifetime | 100% | 0% |
| D6065 | Implant supported porcelain/ceramic crown | One per tooth per lifetime | 100% | 0% |
| D6066 | Implant supported crown – porcelain fused to high noble alloys | One per tooth per lifetime | 100% | 0% |
| D6067 | Implant supported crown – high noble alloys | One per tooth per lifetime | 100% | 0% |
| D6094 | Abutment supported crown – titanium and titanium alloys | One per tooth per lifetime | 100% | 0% |
| D6110 | Implant/abutment supported removable denture for edentulous arch – maxillary | One per tooth per lifetime | 100% | 0% |
| D6111 | Implant/abutment supported removable denture for edentulous arch – mandibular | One per tooth per lifetime | 100% | 0% |
| D6112 | Implant/abutment supported removable denture for partially edentulous arch – maxillary | One per tooth per lifetime | 100% | 0% |
| D6113 | Implant/abutment supported removable denture for partially edentulous arch – mandibular | One per tooth per lifetime | 100% | 0% |
| D6081 | Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure | One per calendar year | 100% | 0% |
| D6090 | Repair of implant/abutment supported prosthesis | One every five calendar years Subject to review, clinical necessity and frequencies | 100% | 0% |
| D6091 | Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment | One every five calendar years | 100% | 0% |
| D6092 | Re-cement or re-bond implant/abutment supported crown | One per tooth per lifetime | 100% | 0% |
| D6093 | Re-cement or re-bond implant/abutment supported fixed partial denture | One per tooth per lifetime | 100% | 0% |
| D6180 | Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments | One per arch per calendar year | 100% | 0% |

| ADA code | Description of benefits | Frequency/limitations | In-network coverage | Out-of-network coverage |
|-----------------|--|---|---------------------|-------------------------|
| Implants | | | | |
| D6096 | Remove broken implant retaining screw | One per tooth per lifetime | 100% | 0% |
| D6190 | Radiographic/surgical implant index, by report | One per tooth per lifetime Subject to review, clinical necessity and frequencies | 100% | 0% |
| D6191 | Semi-Precision abutment – placement | One per tooth per lifetime | 100% | 0% |
| D6192 | Semi-Precision attachment – placement | One per tooth per lifetime | 100% | 0% |

Current Dental Terminology © 2026 American Dental Association. All rights reserved.

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.
- 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 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;
- 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.