Dental Value HI215

Individual Dental

Texas

About your plan

Good oral health means more than an attractive smile. Research shows that oral health, preventive care and regular visits to the dentist are integral to overall health.[1]

The Dental Value HI215 is a dental HMO plan that covers preventive, basic and major dental services provided by the primary care dentist of your choice from our dental network. This plan has no waiting periods, no claims to file, no annual maximum, and no deductibles. Copayments for listed services are applicable only at a participating primary care dentist. Visit **Humana.com/FindCare** to find a participating dentist.

Who can enroll in this plan – Anyone can enroll in this plan.

What to expect

- You will be required to choose a general dentist as your primary care dentist from our network when you enroll in this plan. If you wish to change your primary care dentist in the future, contact Customer Service or go to **HumanaOneMembers.com** to update your plan.
- The service copayments are paid directly to your primary care dentist when you receive dental care. Note, your primary care dentist may or may not provide services for all listed ADA codes.
- Services provided by specialists are not covered by these copays and in some instances are only available through a specialist, like oral surgery procedures. You may however receive services from an in-network specialist and may receive a 25% discount. To find an in-network dental provider, including specialists, visit **Humana.com/FindCare.**

How your plan works

The following provides a summary of the Dental Value HI215 benefits. Services marked with a single asterisk (*) require separate payment of laboratory charges. The laboratory charges must be paid to the primary care dentist in addition to any applicable copayment for the service.

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ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Diagnostic			
D0120	Periodic oral evaluation – established patient	Two per calendar year	No charge
D0140	Limited oral evaluation – problem focused	No limit	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		No charge
D0150	Comprehensive oral evaluation – new or established patient	Two per calendar year	No charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No limit	No charge
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)		No charge
D0180	Comprehensive periodontal evaluation – new or established patient	Two per calendar year	$35
D0210	Intraoral – comprehensive series of radiographic images	One every three years	No charge
D0220	Intraoral – periapical first radiographic image	No limit	No charge
D0230	Intraoral – periapical each additional radiographic image		No charge
D0240	Intraoral – occlusal radiographic image		No charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector		No charge
D0251	Extra-oral posterior dental radiographic image		No charge
D0270	Bitewing – single radiographic image	Two per calendar year	No charge
D0272	Bitewings – two radiographic images		No charge
D0273	Bitewings – three radiographic images		No charge
D0274	Bitewings – four radiographic images		No charge
D0277	Vertical bitewings – seven to eight radiographic images		No charge
D0330	Panoramic radiographic image	One every three years	No charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No limit	No charge
D0415	Collection of microorganisms for culture and sensitivity		No charge
D0425	Caries susceptibility tests		No charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		$70
D0460	Pulp vitality tests	Not covered if a root canal is performed	No charge
D0470	Diagnostic casts	No limit	No charge
D0472	Accession of tissue, gross examination, preparation and transmission of written report		No charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report		No charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report		No charge

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Preventive			
D1110	Prophylaxis – adult	Two per calendar year, age 14 and older	No charge
D1120	Prophylaxis – child	Two per calendar year, age 13 and younger	No charge
D1206	Topical application of fluoride varnish	Two per calendar year, age 15 and younger	No charge
D1208	Topical application of fluoride – excluding varnish	Two per calendar year	No charge
D1310	Nutritional counseling for control of dental disease	No limit	No charge
D1320	Tobacco counseling for the control and prevention of oral disease		No charge
D1330	Oral hygiene instructions		No charge
D1351	Sealant – per tooth	Permanent teeth only, age 16 and younger	$20
D1510*	Space maintainer – fixed, unilateral – per quadrant	Age 14 and younger	$95
D1516	Space maintainer – fixed – bilateral, maxillary		$135
D1517	Space maintainer – fixed – bilateral, mandibular		$135
D1520*	Space maintainer – removable, unilateral – per quadrant		$105
D1526	Space maintainer – removable – bilateral, maxillary		$115
D1527	Space maintainer – removable – bilateral, mandibular		$115
D1551*	Re-cement or re-bond bilateral space maintainer – maxillary	No limit	$20
D1552*	Re-cement or re-bond bilateral space maintainer – mandibular		$20
D1553*	Re-cement or re-bond unilateral space maintainer – per quadrant		$20
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant	Age 14 and younger	$205
Restorative			
D2140	Amalgam – one surface, primary or permanent	No limit	$30
D2150	Amalgam – two surfaces, primary or permanent		$35
D2160	Amalgam – three surfaces, primary or permanent		$40
D2161	Amalgam – four or more surfaces, primary or permanent		$45
D2940	Placement of interim direct restoration		$25
Resin restorative			
D2330	Resin-based composite – one surface, anterior	No limit	$45
D2331	Resin-based composite – two surfaces, anterior		$60
D2332	Resin-based composite – three surfaces, anterior		$75
D2335	Resin-based composite – four or more surfaces (anterior)		$95
D2390	Resin-based composite crown, anterior		$90
D2391	Resin-based composite – one surface, posterior		$70
D2392	Resin-based composite – two surfaces, posterior		$90
D2393	Resin-based composite – three surfaces, posterior		$110
D2394	Resin-based composite – four or more surfaces, posterior		$130
D2510*	Inlay – metallic – one surface	Limited to one per tooth every five years	$345
D2520*	Inlay – metallic – two surfaces		$355
D2530*	Inlay – metallic – three or more surfaces		$365
D2542*	Onlay – metallic – two surfaces		$370

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Resin restorative (continued)			
D2543*	Onlay – metallic – three surfaces	Limited to one per tooth every five years	$380
D2544*	Onlay – metallic – four or more surfaces		$390
D2610*	Inlay – porcelain/ceramic – one surface		$370
D2620*	Inlay – porcelain/ceramic – two surfaces		$380
D2630*	Inlay – porcelain/ceramic – three or more surfaces		$390
D2642*	Onlay – porcelain/ceramic – two surfaces		$395
D2643*	Onlay – porcelain/ceramic – three surfaces		$405
D2644*	Onlay – porcelain/ceramic – four or more surfaces		$415
D2650*	Inlay – resin-based composite – one surface		$345
D2651*	Inlay – resin-based composite – two surfaces		$355
D2652*	Inlay – resin-based composite – three or more surfaces		$365
D2662*	Onlay – resin-based composite – two surfaces		$370
D2663*	Onlay – resin-based composite – three surfaces		$380
D2664*	Onlay – resin-based composite – four or more surfaces		$410
Crowns and bridges			
D2710*	Crown – resin-based composite (indirect)	One per tooth every five years	$410
D2712*	Crown – ¾ resin-based composite (indirect)		$410
D2720*	Crown – resin with high noble metal		$410
D2721	Crown – resin with predominantly base metal		$410
D2722*	Crown – resin with noble metal		$410
D2740*	Crown – porcelain/ceramic		$410
D2750*	Crown – porcelain fused to high noble metal		$410
D2751	Crown – porcelain fused to predominantly base metal		$410
D2752*	Crown – porcelain fused to noble metal		$410
D2753*	Crown – porcelain fused to titanium and titanium alloys		$410
D2780*	Crown – 3/4 cast high noble metal		$410
D2781	Crown – 3/4 cast predominantly base metal		$410
D2782*	Crown – 3/4 cast noble metal		$410
D2783*	Crown – 3/4 porcelain/ceramic		$410
D2790*	Crown – full cast high noble metal		$410
D2791	Crown – full cast predominantly base metal		$410
D2792	Crown – full cast noble metal		$410
D2794*	Crown – titanium and titanium alloys		$410
D2799	Interim crown – further treatment or completion of diagnosis necessary prior to final impression		No charge
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No limit	$25
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		No charge
D2920	Re-cement or re-bond crown		$25
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Limited to one per tooth every five years	$35
D2929	Prefabricated porcelain/ceramic crown – primary tooth	Alternate to D2930	$110
D2930	Prefabricated stainless steel crown – primary tooth	Limited to one per tooth every five years	$110
D2931	Prefabricated stainless steel crown – permanent tooth		$35
D2932	Prefabricated resin crown		$110

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Crowns and bridges (continued)			
D2933	Prefabricated stainless steel crown with resin window	Limited to one per tooth every five years	$110
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth		$110
D2950	Core buildup, including any pins when required	No limit	$80
D2951	Pin retention – per tooth, in addition to restoration		$25
D2952*	Post and core in addition to crown, indirectly fabricated		$175
D2953*	Each additional indirectly fabricated post – same tooth		$140
D2954	Prefabricated post and core in addition to crown		$120
D2955	Post removal		$20
D2957	Each additional prefabricated post – same tooth		$45
D2960	Labial veneer (resin laminate) – direct		$290
D2961*	Labial veneer (resin laminate) – indirect		$425
D2962*	Labial veneer (porcelain laminate) – indirect		$475
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework		$70
D2980	Crown repair necessitated by restorative material failure		$25
D2981	Inlay repair necessitated by restorative material failure	Alternate to D2980	$25
D2982	Onlay repair necessitated by restorative material failure		
D2983	Veneer repair necessitated by restorative material failure		
D6940	Stress breaker	No limit	$170
D6950	Precision attachment		$220
Prosthodontics (fixed)			
D6210*	Pontic – cast high noble metal	Replacement limited to every five years	$410
D6211	Pontic – cast predominantly base metal		$410
D6212*	Pontic – cast noble metal		$410
D6240*	Pontic – porcelain fused to high noble metal		$410
D6241	Pontic – porcelain fused to predominantly base metal		$410
D6242*	Pontic – porcelain fused to noble metal		$410
D6243*	Pontic – porcelain fused to titanium and titanium alloys		$410
D6750*	Retainer crown – porcelain fused to high noble metal		$410
D6751	Retainer crown – porcelain fused to predominantly base metal		$410
D6752*	Retainer crown – porcelain fused to noble metal		$410
D6753*	Retainer crown – porcelain fused to titanium and titanium alloys		$410
D6790	Retainer crown – full cast high noble metal		$410
D6791	Retainer crown – full cast predominantly base metal		$410
D6792*	Retainer crown – full cast noble metal		$410
D6794*	Retainer crown – titanium and titanium alloys		$410
D6930	Re-cement or re-bond fixed partial denture	No limit	$45
Prosthodontics (replacements)			
D5110*	Complete denture – maxillary	Replacement limited to every five years	$550
D5120*	Complete denture – mandibular		$550
D5130*	Immediate denture – maxillary		$550

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Prosthodontics (replacements) (continued)			
D5140*	Immediate denture – mandibular	Replacement limited to every five years	$550
D5211*	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		$495
D5212*	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		$495
D5213*	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$525
D5214*	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$525
D5221*	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		$385
D5222*	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		$385
D5223*	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$605
D5224*	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$605
D5225*	Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)		$525
D5226*	Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)		$525
D5227*	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)		$525
D5228*	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)		$525
D5282*	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary		$445
D5283*	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular		$445
D5284*	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant		$445
D5286*	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant		$445
D5410	Adjust complete denture – maxillary	Limit once per year	$25
D5411	Adjust complete denture – mandibular		$25
D5421	Adjust partial denture – maxillary		$25
D5422	Adjust partial denture – mandibular		$25
D5660*	Add clasp to existing partial denture – per tooth	Replacement limited to every five years	$110

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Endodontics			
D3110	Pulp cap – direct (excluding final restoration)	Each procedure is limited to once per tooth per lifetime	$25
D3120	Pulp cap – indirect (excluding final restoration)		$20
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		$65
D3221	Pulpal debridement, primary and permanent teeth		$135
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		$65
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)		$100
D3310	Endodontic therapy, anterior tooth (excluding final restoration)		$175
D3320	Endodontic therapy, premolar tooth (excluding final restoration)		$270
D3330	Endodontic therapy, molar tooth (excluding final restoration)		$390
D3331	Treatment of root canal obstruction; non-surgical access		$110
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		$110
D3333	Internal root repair of perforation defects		$120
D3351	Apexification/recalcification – initial visit (apical closure/calcification repair of perforations, root resorption, etc.)		$140
D3352	Apexification/recalcification – interim medication replacement		$100
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcification repair of perforations, root resorption, etc.)		$140
D3410	Apicoectomy – anterior		$210
D3421	Apicoectomy – premolar (first root)		$220
D3425	Apicoectomy – molar (first root)		$220
D3426	Apicoectomy (each additional root)		$90
D3430	Retrograde filling – per root		$55
D3450	Root amputation – per root	Not covered in conjunction with procedure D3920	$130
D3910	Surgical procedure for isolation of tooth with rubber dam	Each procedure is limited to once per tooth per lifetime	$50
D3920	Hemisection (including any root removal), not including root canal therapy		$120
D3950	Canal preparation and fitting of preformed dowel or post		$25
Periodontics			
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	No limit	$195
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant		$100
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant		$220

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Periodontics (continued)			
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	No limit	$150
D4245	Apically positioned flap		$225
D4249	Clinical crown lengthening – hard tissue		$220
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant		$425
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant		$400
D4263	Bone replacement graft – retained natural tooth – first site in quadrant		$290
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant		$200
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site		$135
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site		$360
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site		$425
D4270	Pedicle soft tissue graft procedure		$335
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft		$425
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)		$120
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft		$460
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft		$340
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site		$17
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		$255
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site		$276
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns		$135
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns		$115

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Periodontics			
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	A maximum of four (4) quadrants will be paid in any combinations, per 2 years	$85
D4342	Periodontal scaling and root planing – one to three teeth per quadrant		$70
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	One every three years	$80
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	One every five years	$80
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Limited to once per tooth per (12) months to a maximum of three (3) tooth sites per quadrant, and performed no less than three (3) months following active periodontal therapy.	$70
D4910	Periodontal maintenance	Covered only after active periodontal therapy	$70
Extractions/oral and maxillofacial surgery			
D7111	Extraction, coronal remnants – primary tooth	No limit	No charge
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.	$55
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No limit	$60
D7220	Removal of impacted tooth – soft tissue		$75
D7230	Removal of impacted tooth – partially bony		$95
D7240	Removal of impacted tooth – completely bony		$135
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications		$175
D7250	Removal of residual tooth roots (cutting procedure)		$50
D7260	Oroantral fistula closure		$450
D7261	Primary closure of a sinus perforation		$275
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		$95
D7280	Exposure of an unerupted tooth		$160
D7282	Mobilization of erupted or malpositioned tooth to aid eruption		$120
D7284	Excisional biopsy of minor salivary glands		$200
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)		$450
D7286	Incisional biopsy of oral tissue – soft		$155
D7287	Exfoliative cytological sample collection		$70
D7288	Brush biopsy – transepithelial sample collection		$75
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		$50
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$25
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		$90
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$65
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		$210

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Extractions/oral and maxillofacial surgery (continued)			
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	No limit	$285
D7471	Removal of lateral exostosis (maxilla or mandible)		$130
D7472	Removal of torus palatinus		$80
D7473	Removal of torus mandibularis		$80
D7485	Reduction of osseous tuberosity		$75
D7509	Marsupialization of odontogenic cyst		$100
D7510	Incision and drainage of abscess – intraoral soft tissue		$45
D7970	Excision of hyperplastic tissue – per arch		$100
D7971	Excision of pericoronal gingiva		$65
Repair to prosthetics			
D5511	Repair broken complete denture base, mandibular	No limit	$65
D5512	Repair broken complete denture base, maxillary		$65
D5520*	Replace missing or broken teeth – complete denture – per tooth		$65
D5611	Repair resin partial denture base, mandibular		$65
D5612	Repair resin partial denture base, maxillary		$65
D5621	Repair cast partial framework, mandibular		$65
D5622	Repair cast partial framework, maxillary		$65
D5630*	Repair or replace broken retentive clasping materials – per tooth		$65
D5640*	Replace missing or broken teeth – partial denture – per tooth		$65
D5650*	Add tooth to existing partial denture – per tooth		$60
D5670*	Replace all teeth and acrylic on cast metal framework (maxillary)		$255
D5671*	Replace all teeth and acrylic on cast metal framework (mandibular)		$350
D5710*	Rebase complete maxillary denture		$230
D5711*	Rebase complete mandibular denture		$230
D5720*	Rebase maxillary partial denture		$230
D5721*	Rebase mandibular partial denture		$230
D5725*	Rebase hybrid prosthesis		$230
D5730	Reline complete maxillary denture (direct)		$110
D5731	Reline complete mandibular denture (direct)		$110
D5740	Reline maxillary partial denture (direct)		$110
D5741	Reline mandibular partial denture (direct)		$110
D5750*	Reline complete maxillary denture (indirect)		$180
D5751*	Reline complete mandibular denture (indirect)		$180
D5760*	Reline maxillary partial denture (indirect)		$180
D5761*	Reline mandibular partial denture (indirect)		$180
D5765*	Soft liner for complete or partial removable denture – indirect		$180
D5810*	Interim complete denture (maxillary)		$300
D5811*	Interim complete denture (mandibular)		$300
D5820*	Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary		$210
D5821*	Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular		$210
D5850	Tissue conditioning, maxillary		$45
D5851	Tissue conditioning, mandibular		$45

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Repair to prosthetics (continued)			
D6214*	Pontic – titanium and titanium alloys	No limit	$410
D6245*	Pontic – porcelain/ceramic		$410
D6250*	Pontic – resin with high noble metal		$410
D6251	Pontic – resin with predominantly base metal		$410
D6252*	Pontic – resin with noble metal		$410
D6253*	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression		No charge
D6545*	Retainer – cast metal for resin bonded fixed prosthesis		$300
D6548*	Retainer – porcelain/ceramic for resin bonded fixed prosthesis		$300
D6600*	Retainer inlay – porcelain/ceramic, two surfaces		$410
D6601*	Retainer inlay – porcelain/ceramic, three or more surfaces		$410
D6602*	Retainer inlay – cast high noble metal, two surfaces		$410
D6603*	Retainer inlay – cast high noble metal, three or more surfaces		$410
D6604	Retainer inlay – cast predominantly base metal, two surfaces		$410
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces		$410
D6606*	Retainer inlay – cast noble metal, two surfaces		$410
D6607*	Retainer inlay – cast noble metal, three or more surfaces		$410
D6608*	Retainer onlay – porcelain/ceramic, two surfaces		$410
D6609*	Retainer onlay – porcelain/ceramic, three or more surfaces		$410
D6610*	Retainer onlay – cast high noble metal, two surfaces		$410
D6611*	Retainer onlay – cast high noble metal, three or more surfaces		$410
D6612	Retainer onlay – cast predominantly base metal, two surfaces		$410
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces		$410
D6614*	Retainer onlay – cast noble metal, two surfaces		$410
D6615*	Retainer onlay – cast noble metal, three or more surfaces		$410
D6624*	Retainer inlay – titanium		$410
D6634*	Retainer onlay – titanium		$410
D6710*	Retainer crown – indirect resin based composite		$410
D6720*	Retainer crown – resin with high noble metal		$410
D6721	Retainer crown – resin with predominantly base metal		$410
D6722*	Retainer crown – resin with noble metal		$410
D6740*	Retainer crown – porcelain/ceramic		$410
D6780*	Retainer crown – 3/4 cast high noble metal		$410
D6781	Retainer crown – 3/4 cast predominantly base metal		$410
D6782*	Retainer crown – 3/4 cast noble metal		$410
D6783*	Retainer crown – 3/4 porcelain/ceramic		$410
D6784*	Retainer crown – 3/4 titanium and titanium alloys		$410

ADA Code	Description of Benefits	Frequency/Limitations	Member Co-Pay
Adjunctive general services			
D9110	Palliative treatment of dental pain – per visit	No limit – only covered in FL and TX	$20
D9215	Local anesthesia in conjunction with operative or surgical procedures	No limit	No charge
D9222	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	Limited to the removal of partial, or complete boney impacted teeth	$102
D9223	Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof		$87
D9230	Administration of nitrous oxide	No limit	$45
D9239	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	Limited to the removal of partial, or complete boney impacted teeth	$102
D9243	Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof		$87
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof		$87
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof		$87
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No limit	No Charge
D9951	Occlusal adjustment – limited		$45
D9952	Occlusal adjustment – complete		$205
Bleaching			
D9972	External bleaching – per arch – performed in office	No limit	$210
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays		No charge
Appointments			
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	No limit	$45
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed		$15
D9440	Office visit – after regularly scheduled hours		$55
D9986	Missed appointment		$10

* Services marked with a single asterisk (*) require separate payment of laboratory charges. The laboratory charges must be paid to the primary care dentist in addition to any applicable copayment for the service.

Note:

- If further clarification regarding your coverage and benefits is needed please ask your dentist for a pretreatment estimate.
- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Composite (white) fillings are only covered on anterior (front) teeth. An alternate benefit is allowed for composite fillings on posterior (back) teeth where the plan will cover the cost of an amalgam (silver) filling and the member is responsible for any cost over the covered amount.
- The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal.
- When crown or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.

Important to know: Payment may include an administration fee. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment.

Footnote

1. “Gum Diseases and Other Diseases,” American Academy of Periodontology, last accessed Oct. 6, 2025, https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/

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Limitations and Exclusions

This is an outline of the limitations and exclusions for this Humana individual dental plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Plan does not provide coverage for the following:

A. No service of any dentist other than a Participating General Dentist or Participating Specialty Dentist will be covered by Plan, except for emergency care as described in the Emergency Care section. This does not include Dentally Necessary services performed by non-Participating Dentists approved by the Plan.

B. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

C. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits (except for palliative (emergency) treatment) or transfer Dental Facilities.

D. Any dental treatment started prior to the Member's effective date for eligibility of benefits. This does not apply to Covered Dental Care Services in progress if such treatment is completed by a Participating Dentist. This also does not apply to Orthodontic treatment in progress that was covered under the Contractholder's prior plan. To be covered under this Plan, Orthodontic treatment must be shown on your Schedule of Benefits and You must have the subsequent treatment provided by a Participating Dentist.

E. Services which in the opinion of the Participating General Dentist, Participating Specialty Dentist, or Plan that are not Dentally Necessary to establish and/or maintain the Member's oral health.

F. Any services that are not appropriate or customarily performed for the given condition, do not have uniform professional endorsement, do not have a favorable prognosis, or are experimental or investigational.

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

H. Any service or procedure which the Participating General Dentist or Participating Specialty Dentist is unable to perform because of the general health or physical limitations of the Member.

I. Procedures, appliances or restorations to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); or replacement of lost, missing or stolen appliances.

J. Services performed primarily for cosmetic purposes, unless otherwise listed as covered cosmetic services on Your Schedule of Benefits.

K. Services provided by a Participating Pediatric Dentist are limited to children through age seven.

L. Removal of asymptomatic third molars is not covered unless pathology (disease) exists. Examples of symptomatic conditions include decay, cysts, unmanageable periodontal disease, infection, and resorption of adjacent tooth.

M. Frequency and/or age limitations may apply. See your Schedule of Benefits and Copayments for details.

Dental Limitations and Exclusions (continued)

N. Worker's Compensation

1. If we pay benefits but determine that the benefits were for the treatment of bodily injury or sickness that arose from or was sustained in the course of any occupation or employment for compensation, profit or gain, we have the right to recover that payment. We will exercise our right to recover against You.

2. The recovery rights will be applied even though:

   a. The Workers' Compensation benefits are in dispute or are made by means or settlement or compromise;

   b. No final determination is made that bodily injury or sickness was sustained in the course of, or resulted from, Your employment;

   c. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or

   d. Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

3. You agree that, in consideration for the coverage provided by the Contract, We will be notified of any Workers' Compensation claim that you make, and You agree to reimburse us as described above.

O. Crowns, inlays, onlays, or veneers for the purpose of:

1. Altering vertical dimension of teeth;

2. Restoration or maintenance of occlusion;

3. Splinting teeth, including multiple abutments; or

4. Replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction).

Offered by DentiCare, Inc. (d/b/a/ CompBenefits).

Policy number: DHMO Contract. TX.001

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.

A person should not send money to Humana in response to this advertisement and a person cannot obtain coverage under this health benefit plan without completing application for coverage.

Humana.