Your Dental & Vision Benefits Guide 2023-2024

Living what matters

City of St Petersburg

Humana
Feel good about choosing a HumanaDental plan
The HumanaDental HS Series dental plan has you covered for any circumstance. Whether you simply need routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

Use your HumanaDental benefits
After you enroll in a plan and receive your ID card, you can manage your plan information on your personal home page on Humana.com.
- You have the freedom to select any participating general dentist as your primary care dentist. To select a dental provider from our network, simply visit Humana.com. Once there, you can also check your benefits, email us and get a new or temporary ID card. If you prefer, contact us at 1-800-342-5209.
- Life without claim forms! With the HumanaDental Prepaid plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and you will pay any copayment or discounted charges at the time of service.

Good health starts with a healthy mouth

Make dental visits a priority
One of the first lines of defense in overall health is dental care. Regular dental cleanings can help manage problems throughout the body, such as heart disease, diabetes, and stroke. The HumanaDental Prepaid plan enables you to take better care of your teeth, and you’ll pay less for your dental care doing so.

Go to MyDentalIQ.com
Take a health risk assessment that immediately rates your dental health knowledge. You’ll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Questions?
Check out Humana.com
Call 1-800-233-4013, Monday through Friday, 8 a.m. to 6 p.m. (TDD: 1-800-325-2025)

The HumanaDental Prepaid plans focus on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. HS plans copayments for listed procedures are applicable at either a participating general dentist or a participating specialist dentist.

A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services: Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Visit Humana.com to find a participating specialist.

Summary of services

Services marked with a single asterisk (*) below also require separate payment of laboratory charges, not to exceed $200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

<table>
<thead>
<tr>
<th>Appointments</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9310 Consultation (diagnostic service provided by dentist other than practitioner providing treatment)</td>
<td>no charge</td>
</tr>
<tr>
<td>D9430 Office visit (normal hours)</td>
<td>no charge</td>
</tr>
<tr>
<td>D9440 Office visit (after regularly scheduled hours)</td>
<td>$30.00</td>
</tr>
<tr>
<td>D9986 Missed appointment</td>
<td>$10.00</td>
</tr>
<tr>
<td>D9987 Cancelled appointment</td>
<td>$10.00</td>
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<tr>
<td>D9999 Emergency visit during regular scheduled hours, by report</td>
<td>$20.00</td>
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<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Member pays</th>
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<tbody>
<tr>
<td>D0120 Periodic oral examination (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0140 Limited/comprehensive/detailed and extensive oral eval</td>
<td>no charge</td>
</tr>
<tr>
<td>D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>no charge</td>
</tr>
<tr>
<td>D0150 Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0160 Limited/comprehensive/detailed and extensive oral eval</td>
<td>no charge</td>
</tr>
<tr>
<td>D0170 Re-evaluation—problem focused (not post-operative visit)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0180 Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0210 X-ray intraoral—complete series including bitewings (once per three calendar years)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0220 X-ray intraoral—periapical, first radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0230 X-ray intraoral—periapical, each additional radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0240 X-rays intraoral—occlusal radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0250 Extra-oral—2D projection radiographic image created using a stationary radiation source, and detector</td>
<td>no charge</td>
</tr>
<tr>
<td>D0270 X-ray bitewing—single radiographic image (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0272 X-ray bitewing—two radiographic images (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0273 X-ray bitewing—three radiographic images (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0274 Bitewings—four radiographic images (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0277 X-ray bitewings, vertical—seven to eight radiographic images (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0330 Panoramic radiographic image (once per three calendar years)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0340 Oral/facial photography images</td>
<td>no charge</td>
</tr>
<tr>
<td>D0415 Collect microorganisms culture &amp; sensitivity</td>
<td>no charge</td>
</tr>
<tr>
<td>D0425 Caries susceptibility tests</td>
<td>no charge</td>
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<tr>
<td>D0431 Oral cancer screening using a special light source</td>
<td>$50.00</td>
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<tr>
<td>D0460 Pulp vitality tests (not covered if a root canal is performed)</td>
<td>no charge</td>
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<tr>
<td>D0470 Diagnostic casts</td>
<td>no charge</td>
</tr>
<tr>
<td>D0472 Pathology report—gross examination of lesion</td>
<td>no charge</td>
</tr>
<tr>
<td>D0473 Pathology report—microscopic examination of lesion</td>
<td>no charge</td>
</tr>
<tr>
<td>D0474 Pathology report—microscopic examination of lesion and area</td>
<td>no charge</td>
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<table>
<thead>
<tr>
<th>Preventive</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110 Prophylaxis—adult, routine (limited to twice in any 12 calendar months, by primary care dentist)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1111 Additional—adult prophylaxis, with or without fluoride (maximum of two additional per year)</td>
<td>$35.00</td>
</tr>
<tr>
<td>D1120 Prophylaxis—child (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1121 Additional—child prophylaxis, with or without fluoride (maximum of two additional per year)</td>
<td>$25.00</td>
</tr>
<tr>
<td>D1206 Topical application of fluoride varnish (for child &lt;16) (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1208 Topical application of fluoride—excluding varnish (limited to twice in any 12 calendar months)</td>
<td>no charge</td>
</tr>
</tbody>
</table>
Humana Dental Prepaid HS195 Plan with Implants

City of St Petersburg

D1310 Nutrition counseling for the control of dental disease ................................................................. no charge
D1320 Tobacco counseling services for the control or prevention of oral disease .................. no charge
D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use. no charge
D1330 Oral hygiene instruction .................................................. no charge
D1351 Sealant—per tooth (permanent teeth only to age 16) .................................................. no charge
D1510* Space Maintainer - fixed, unilateral - per quadrant (through age 14) ...................... $ 25.00
D1516* Space maintainer – fixed - bilateral, maxillary (through age 14) .................. $ 25.00
D1517* Space maintainer – fixed - bilateral, mandibular (through age 14) .................. $ 25.00
D1520* Space Maintainer - removable, unilateral - per quadrant (through age 14) .......... $ 35.00
D1526* Space maintainer - removable - bilateral, maxillary (through age 14) .......... $ 35.00
D1527* Space maintainer – removable - bilateral, mandibular (through age 14) .......... $ 35.00
D1551 Re-cement or re-bond bilateral space maintainer—maxillary ................................. $ 15.00
D1552 Re-cement or re-bond bilateral space maintainer—mandibular ................................. $ 15.00
D1553 Re-cement or re-bond unilateral space maintainer—per quadrant ...................... $ 15.00
D1556 Removal of fixed, unilateral space maintainer—per quadrant ........................................... $ 15.00
D1557 Removal of fixed bilateral space maintainer—maxillary ................................................. $ 15.00
D1558 Removal of fixed bilateral space maintainer—mandibular ................................................. $ 15.00
D1575 Distal shoe space maintainer—fixed, unilateral—per quadrant (through age 14; primary teeth only) ........................................................................................................... $ 55.00

Restorative  Member pays

D2140 Amalgam—one surface, primary or permanent ................................................................. no charge
D2150 Amalgam—two surfaces, primary or permanent ................................................................. no charge
D2160 Amalgam—three surfaces, primary or permanent ................................................................. no charge
D2161 Amalgam—four or more surfaces, primary or permanent ................................................. no charge
D2940 Protective restoration .................................................. no charge

Resin restorative  (inlays and onlays limited to one per tooth every five years)  Member pays

D2330 Resin based composite—one surface, anterior ................................................................. no charge
D2331 Resin based composite—two surfaces, anterior ................................................................. no charge
D2332 Resin based composite—three surfaces, anterior ................................................................. no charge
D2335 Resin based composite—four or more surfaces or involving incisal angle (anterior) ................................................................. no charge
D2390 Resin based composite crown, anterior ................................................................. $ 30.00

D2391 Resin based composite—one surface, posterior ................................................................. $ 30.00
D2392 Resin based composite—two surfaces, posterior ................................................................. $ 45.00
D2393 Resin based composite—three surfaces, posterior ................................................................. $ 65.00
D2394 Resin based composite—four or more surfaces, posterior ................................................. $ 65.00
D2510* Inlay—metallic, one surface ................................................................. $ 225.00
D2520* Inlay—metallic, two surfaces ................................................................. $ 235.00
D2530* Inlay—metallic, three or more surfaces ................................................................. $ 245.00
D2540* Onlay—metallic, two surfaces ................................................................. $ 245.00
D2543* Onlay—metallic, three surfaces ................................................................. $ 260.00
D2544* Onlay—metallic, four or more surfaces ................................................................. $ 270.00
D2610* Inlay—porcelain/ceramic, one surface ................................................................. $ 245.00
D2620* Inlay—porcelain/ceramic, two surfaces ................................................................. $ 245.00
D2630* Inlay—porcelain/ceramic, three or more surfaces .................................................. $ 245.00
D2642* Onlay—porcelain/ceramic, two surfaces ................................................................. $ 245.00
D2643* Onlay—porcelain/ceramic, three surfaces ................................................................. $ 245.00
D2644* Onlay—porcelain/ceramic, four or more surfaces .................................................. $ 245.00
D2650* Inlay—resin based composite, one surface ................................................................. $ 245.00
D2651* Inlay—resin based composite, two surfaces ................................................................. $ 245.00
D2652* Inlay—resin based composite, three or more surfaces .................................................. $ 245.00
D2662* Onlay—resin based composite, two surfaces ................................................................. $ 245.00
D2663* Onlay—resin based composite, three surfaces ................................................................. $ 245.00
D2664* Onlay—resin based composite, four or more surfaces .................................................. $ 245.00

Crown and bridge (limited to one per tooth every five years)  Member pays

D2710* Crown—resin based composite, indirect ................................................................. $ 245.00
D2712* Crown—3/4 resin based composite, indirect ................................................................. $ 245.00
D2720* Crown—resin with high noble metal ................................................................. $ 245.00
D2721 Crown—resin with predominantly base metal ................................................................. $ 245.00
D2722* Crown—resin with noble metal ................................................................. $ 245.00
D2740* Crown - porcelain/ceramic ................................................................. $ 245.00
D2750* Crown—porcelain fused to high noble metal ................................................................. $ 245.00
D2751 Crown—porcelain fused to predominantly base metal ................................................................. $ 245.00
D2752* Crown—porcelain fused to noble metal ................................................................. $ 245.00
D2753* Crown—porcelain fused to titanium and titanium alloys ................................................................. $ 245.00
D2780* Crown—3/4 cast high noble metal ................................................................. $ 245.00
D2781 Crown—3/4 cast predominantly base metal ................................................................. $ 245.00
D2782* Crown—3/4 cast noble metal ................................................................. $ 245.00
D2783* Crown—3/4 porcelain/ceramic ................................................................. $ 245.00
D2790* Crown—full cast high noble metal ................................................................. $ 245.00
D2791 Crown—full cast predominantly base metal ................................................................. $ 245.00
D2792* Crown—full cast noble metal ................................................................. $ 245.00
D2794* Crown—titanium and titanium alloy ................................................................. $ 245.00
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 charge

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D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core .................. no charge
D2920 Re-cement or re-bond crown .................. no charge
D2928 Prefabricated porcelain/ceramic crown—permanent tooth ........................................ $ 45.00
D2929 Crown—Prefabricated porcelain/ceramic crown—primary tooth ...................................... $ 25.00
D2930 Prefabricated stainless steel crown—primary tooth ..................................................... $ 25.00
D2931 Prefabricated stainless steel crown—permanent tooth .................................................. $ 25.00
D2932 Prefabricated resin crown .......................... $ 45.00
D2933 Prefabricated stainless steel crown with resin window ............................................... $ 45.00
D2950 Core buildup, including any pins ................ $ 70.00
D2951 Pin retention—per tooth, in addition to restoration ......................................................... $ 10.00
D2952 Cast post and core in addition to crown ................................................................. $ 50.00
D2953 Each additional cast post—same tooth ........................................................................ $ 50.00
D2954 Prefabricated post and core in addition to crown .......................................................... $ 30.00
D2955 Post removal (not in conjunction with endodontic therapy) ........................................... $ 10.00
D2957 Each additional prefabricated post—same tooth, base metal post .................................... $ 30.00
D2960 Labial Veneer (Resin Laminate) - direct ................................................................. $ 250.00
D2961 Labial Veneer (Resin Laminate) - indirect .................................................................. $ 300.00
D2962 Labial Veneer (porcelain Laminate) - indirect ................................................................. $ 350.00
D2970 Temporary crown (fractured tooth) .................................................................................... no charge
D2971 Additional procedures to customize a crown to fit under an existing partial denture framework . $ 50.00
D2980 Crown repair, necessitated by restorative material failure .................................................. no charge
D2981 Inlay repair, necessitated by restorative material failure .................................................. no charge
D2982 Onlay repair, necessitated by restorative material failure .................................................. no charge
D2983 Veneer repair, necessitated by restorative material failure .................................................. no charge
D6940 Stress breaker .......................................................... $ 110.00
D6950 Precision attachment, separate from prosthesis .............................................................. $ 195.00
D6980* Fixed partial denture repair necessitated by restorative material failure ....................... $ 45.00

Prosthodontics (fixed) (replacement limited to every five years, adjustments once per year) Member pays

D6210* Pontic—cast high noble metal .............................................................. $ 245.00
D6211 Pontic—cast predominantly base metal ................................................................. $ 245.00
D6212* Pontic—cast noble metal ............................................................................... $ 245.00
D6240* Pontic—porcelain fused to high noble metal ......................................................... $ 245.00
D6241 Pontic—porcelain fused to predominantly base metal ................................................. $ 245.00
D6242* Pontic—porcelain fused to noble metal ................................................................ $ 245.00
D6243* Pontic—porcelain fused to titanium and titanium alloys ........................................... $ 245.00
D6750* Retainer crown—porcelain fused to high noble metal ............................................... $ 245.00
D6751 Retainer crown—porcelain fused to predominantly base metal ....................................... $ 245.00
D6752* Retainer crown—porcelain fused to noble metal ......................................................... $ 245.00
D6753* Crown—porcelain fused to titanium and titanium alloys ............................................... $ 245.00
D6790* Retainer crown—full cast high noble metal ................................................................. $ 245.00
D6791 Retainer crown—full cast predominantly base metal ...................................................... $ 245.00
D6792* Retainer crown—full cast noble metal ........................................................................... $ 245.00
D6794* Retainer crown—titanium and titanium alloy ................................................................. $ 245.00
D6930 Re-cement or re-bond fixed partial denture (per unit) ................................................. no charge

Prosthodontics (replacement limited to every five years) Member pays

D5110* Complete denture—maxillary ....................................................................................... $ 325.00
D5120* Complete denture—mandibular ..................................................................................... $ 325.00
D5130* Immediate denture—maxillary ...................................................................................... $ 350.00
D5140* Immediate denture—mandibular ...................................................................................... $ 350.00
D5211* Maxillary partial denture—resin base (including retentive/clasping materials, rests and teeth) ................................................................. $ 400.00
D5212* Mandibular partial denture—resin base (including retentive/clasping materials, rests and teeth) ................................................................. $ 400.00
D5213* Maxillary partial denture - cast metal (including retentive/clasping materials, rests and teeth) ................................................................. $ 425.00
D5214* Mandibular partial denture - cast metal (including retentive/clasping materials, rests and teeth) ................................................................. $ 425.00
D5221 Immediate maxillary partial denture—resin base (including retentive/clasping materials, rests and teeth) ................................................................. $ 350.00
D5222 Immediate mandibular partial denture—resin base (including retentive/clasping materials, rests and teeth) ................................................................. $ 350.00
D5223 Immediate maxillary partial denture—cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ................................................................. $ 350.00
D5224 Immediate mandibular partial denture—cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) ................................................................. $ 350.00
D5225* Upper Partial Denture - Flexible (Including retentive/clasping materials, rests and teeth) ................................................................. $ 425.00
D5226* Lower Partial Denture - Flexible (Including retentive/clasping materials, rests and teeth) ................................................................. $ 425.00
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) ................................................................. $ 425.00
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) ................................................................. $ 425.00
D5282* Removable unilateral partial denture - one piece metal (including retentive/clasping materials, rests and teeth), maxillary ................................................................. $ 300.00
D5283* Removable unilateral partial denture - one piece metal (including retentive/clasping materials, rests and teeth), mandibular ................................................................. $ 300.00

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<table>
<thead>
<tr>
<th>Procedure</th>
<th>Member pays</th>
<th>City of St Petersburg</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3284* Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth)</td>
<td>$300.00</td>
<td></td>
</tr>
<tr>
<td>D3286* Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth)</td>
<td>$300.00</td>
<td></td>
</tr>
<tr>
<td>D3410 Adjust complete denture—maxillary</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>D3411 Adjust complete denture—mandibular</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>D3421 Adjust partial denture—maxillary</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>D3422 Adjust partial denture—mandibular</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>D5660* Add clasp to existing partial denture—per tooth</td>
<td>$35.00</td>
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### Endodontics

(Each procedure limited to once per tooth per life)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Member pays</th>
<th>City of St Petersburg</th>
</tr>
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<tbody>
<tr>
<td>D3110 Pulp cap—direct (excluding final restoration)</td>
<td>$5.00</td>
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<tr>
<td>D3120 Pulp cap—indirect (excluding final restoration)</td>
<td>$5.00</td>
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</tr>
<tr>
<td>D3220 Therapeutic pulpotomy (excluding final restoration)</td>
<td>$30.00</td>
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</tr>
<tr>
<td>D3221 Pulpal debridement, primary and permanent teeth (Not to be used when root canal is done on the same day)</td>
<td>$55.00</td>
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<tr>
<td>D3230 Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)</td>
<td>$40.00</td>
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<tr>
<td>D3240 Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)</td>
<td>$40.00</td>
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</tr>
<tr>
<td>D3310 Root canal therapy—anterior tooth (excluding final restoration)</td>
<td>$100.00</td>
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<tr>
<td>D3320 Endodontic therapy, premolar tooth (excluding final restorations)</td>
<td>$152.00</td>
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<tr>
<td>D3330 Endodontic therapy, molar tooth (excluding final restorations)</td>
<td>$210.00</td>
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<tr>
<td>D3331 Treatment of root canal obstruction—non-surgical access</td>
<td>$85.00</td>
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</tr>
<tr>
<td>D3332 Incomplete endodontic therapy—inoperable or fractured tooth</td>
<td>$96.00</td>
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</tr>
<tr>
<td>D3333 Internal root repair of perforation defects</td>
<td>$85.00</td>
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<tr>
<td>D3346 Retreatment of previous root canal therapy—anterior</td>
<td>$180.00</td>
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<tr>
<td>D3347 Retreatment of previous root canal therapy—bicuspids</td>
<td>$280.00</td>
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<tr>
<td>D3348 Retreatment of previous root canal therapy—molars</td>
<td>$325.00</td>
<td></td>
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<tr>
<td>D3351 Apexification/recalification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)</td>
<td>$70.00</td>
<td></td>
</tr>
<tr>
<td>D3352 Apexification/recalification—interim medication replacement (includes any necessary radiographs)</td>
<td>$70.00</td>
<td></td>
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<tr>
<td>D3353 Apexification/recalification—final visit (includes any necessary radiographs)</td>
<td>$70.00</td>
<td></td>
</tr>
<tr>
<td>D3410 Apicoectomy—anterior</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D3421 Apicoectomy—premolar (first root)</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D3425 Apicoectomy—molar (first root)</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D3426 Apicoectomy—each additional root</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>D3430 Retrograde filling—per root</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>D3450 Root amputation—per root (not covered in conjunction with procedure D3920)</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D3910 Surgical procedure to isolate tooth with rubber dam</td>
<td>$19.00</td>
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</tr>
<tr>
<td>D3920 Hemisection not included in root canal therapy</td>
<td>$90.00</td>
<td></td>
</tr>
<tr>
<td>D3950 Canal preparation and fitting of preformed dowel or post</td>
<td>$15.00</td>
<td></td>
</tr>
</tbody>
</table>

### Periodontics (gum treatment)

(Each procedure limited to once per tooth per life)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Member pays</th>
<th>City of St Petersburg</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210 Gingivectomy/gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$110.00</td>
<td></td>
</tr>
<tr>
<td>D4211 Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$83.00</td>
<td></td>
</tr>
<tr>
<td>D4240 Gingival flap, including root planing—four or more teeth, per quadrant</td>
<td>$150.00</td>
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</tr>
<tr>
<td>D4241 Gingival flap, including root planing—one to three teeth, per quadrant</td>
<td>$113.00</td>
<td></td>
</tr>
<tr>
<td>D4245 Apically positioned flap</td>
<td>$165.00</td>
<td></td>
</tr>
<tr>
<td>D4249 Clinical crown lengthening—hard tissue</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>D4260 Osseous surgery (including elevation of a full thickness flap and closure)</td>
<td>$300.00</td>
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</tr>
<tr>
<td>D4261 Osseous surgery (including elevation of a full thickness flap and closure)</td>
<td>$225.00</td>
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</tr>
<tr>
<td>D4263 Bone replacement graft—retained natural tooth—first site in quadrant</td>
<td>$180.00</td>
<td></td>
</tr>
<tr>
<td>D4264 Bone replacement graft—retained natural tooth—each additional site in quadrant</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D4265 Biologic materials to aid in soft and osseous tissue regeneration, per site</td>
<td>$95.00</td>
<td></td>
</tr>
<tr>
<td>D4266 Guided tissue regeneration—resorbable barrier, per site</td>
<td>$215.00</td>
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</tr>
<tr>
<td>D4267 Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)</td>
<td>$255.00</td>
<td></td>
</tr>
<tr>
<td>D4270 Pedicle soft tissue graft procedure</td>
<td>$245.00</td>
<td></td>
</tr>
<tr>
<td>D4271 Free soft tissue graft procedure (including donor site surgery)</td>
<td>$245.00</td>
<td></td>
</tr>
<tr>
<td>D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites)</td>
<td>$75.00</td>
<td></td>
</tr>
<tr>
<td>D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>D4275 Non-autogenous connective tissue graft (including recipient site and donor material)</td>
<td>$380.00</td>
<td></td>
</tr>
<tr>
<td>D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft</td>
<td>$245.00</td>
<td></td>
</tr>
</tbody>
</table>

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HumanaDental Prepaid HS195 Plan with Implants

D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft site .................................................. $ 120.00

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 .................................................. $ 75.00

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 .................................................. $ 380.00

D4322 Splint – intra-coronal; natural teeth or prosthetic crowns ................................................................. $ 95.00

D4323 Splint – extra-coronal; natural teeth or prosthetic crowns ................................................................. $ 85.00

D4341 Periodontal scaling and root planing—four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months) ................................................................. $ 50.00

D4342 Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342) .................................................................................. $ 38.00

D4346 Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120) .................................................................................. $ 50.00

D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years) .................................................................................. $ 50.00

D4381 Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three teeth sites per quadrant, and performed no less than three months following active periodontal therapy) .................................................................................. $ 65.00

D4910 Periodontal maintenance (covered only after active periodontal therapy) .................................................. $ 40.00

D4911 Additional periodontal maintenance procedures (beyond two per 12 months) .................................................. $ 55.00

**Extractions/oral and maxillofacial surgery**  
Member pays

D7111 Extraction, coronal remnants – primary tooth .................................................. $ 5.00

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) .................................................. $ 5.00

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated .................................................................................. $ 30.00

D7220 Removal of impacted tooth—soft tissue .................................................. $ 50.00

D7230 Removal of impacted tooth—partially bony .................................................. $ 65.00

D7240 Removal of impacted tooth—completely bony .................................................. $ 80.00

D7241 Removal of impacted tooth—completely bony, unusual complications by report .................................................. $ 100.00

D7250 Surgical removal of residual tooth roots .................................................. $ 40.00

D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth .................................................. $ 50.00

D7280 Exposure of an unerupted tooth (excluding wisdom teeth) .................................................. $ 100.00

D7282 Mobilization of erupted or malposed tooth to aid eruption .................................................. $ 90.00

D7283 Placement of device to facilitate eruption of impacted tooth .................................................. $ 90.00

D7285 Incisional biopsy of oral tissue—hard (bone, tooth) .................................................. $ 150.00

D7286 Incisional biopsy of oral tissue—soft (all others) .................................................. $ 60.00

D7287 Exfoliative cytological sample collection .................................................. $ 50.00

D7288 Brush biopsy—transepithelial sample collection .................................................. $ 50.00

D7310 Alveoloplasty in conjunction with extractions—per quadrant .................................................. $ 40.00

D7311 Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant .................................................. $ 15.00

D7320 Alveoloplasty not in conjunction with extractions—per quadrant .................................................. $ 60.00

D7321 Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant .................................................. $ 25.00

D7471 Removal of lateral exostosis (maxilla or mandible) .................................................. $ 80.00

D7472 Removal of torus palatinus .................................................. $ 60.00

D7473 Removal of torus mandibularis .................................................. $ 60.00

D7485 Reduction of osseous tuberosity .................................................. $ 60.00

D7510 Incision and drainage of abscess—intraoral soft tissue .................................................. $ 35.00

D7511 Incision and drainage of abscess—intraoral soft tissue, complicated (includes drainage of multiple fascial spaces) .................................................. $ 35.00

D7520 Incision and drainage of abscess—extraoral soft tissue .................................................. $ 35.00

D7521 Incision and drainage of abscess—extraoral soft tissue, complicated (includes drainage of multiple fascial spaces) .................................................. $ 35.00

D7910 Suture of recent small wounds up to 5 cm. .................................................. $ 25.00

D7961 Buccal / labial frenectomy (frenulectomy) .................................................. $ 50.00

D7962 Lingual frenectomy (frenulectomy) .................................................. $ 50.00

D7963 Frenuloplasty .................................................. $ 50.00

D7970 Excision hyperplastic tissue—per arch .................................................. $ 55.00

D7971 Excision of pericoronary gingiva .................................................. $ 40.00

**Repairs to prosthetics**  
Member pays

D5511* Repair broken complete denture base, mandibular .................................................. $ 35.00

D5512* Repair broken complete denture base, maxillary .................................................. $ 35.00

D5520* Replace missing or broken teeth—complete denture (each tooth) .................................................. $ 35.00

D5611* Repair resin partial denture base, mandibular .................................................. $ 35.00

D5612* Repair resin partial denture base, maxillary .................................................. $ 35.00

D5621* Repair cast partial framework, mandibular .................................................. $ 35.00

D5622* Repair cast partial framework, maxillary .................................................. $ 35.00

*Note: Member pays the remaining balance after insurance has paid.
Humana Dental Prepaid HS195 Plan with Implants

City of St Petersburg

$245.00

D6606* Retainer inlay—cast noble metal, two surfaces

D6607* Retainer inlay—cast noble metal, three or more surfaces

D6608* Retainer onlay—porcelain/ceramic, two surfaces

D6609* Retainer onlay—porcelain/ceramic, three or more surfaces

D6610* Retainer onlay—cast high noble metal, two surfaces

D6611* Retainer onlay—cast high noble metal, three or more surfaces

D6612 Retainer onlay—cast predominantly base metal, two surfaces

D6613 Retainer onlay—cast predominantly base metal, three or more surfaces

D6614* Retainer onlay—cast noble metal, two surfaces

D6615* Retainer onlay—cast noble metal, three or more surfaces

D6710* Retainer crown—indirect resin based composition

D6720* Retainer crown—resin with high noble metal

D6721 Retainer crown—resin with predominantly base metal

D6722* Retainer crown—resin with noble metal

D6740* Retainer crown—porcelain/ceramic

D6780* Retainer crown—3/4 cast high noble metal

D6781 Retainer crown—3/4 cast predominantly base metal

D6782* Retainer crown—3/4 cast noble metal

D6783* Retainer crown—3/4 porcelain/ceramic, denture

D6784 Retainer crown—3/4 titanium and titanium alloys

**Adjuvative general service**

D9110 Palliative (emergency) treatment of dental pain—minor procedure

D9110 Local anesthesia not in conjunction with operative or surgical procedures

D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures

D9222 Deep sedation/general anesthesia—first 15 minutes

D9223 Deep sedation/general anesthesia—each subsequent 15 minute increment

D9230 Inhalation of nitrous oxide/analgesia, anxiolysis

D9239 Intravenous moderate (conscious) sedation/analgesia—first 15 minutes

D9243 Intravenous moderate (conscious) sedation/analgesia—each subsequent 15 minute increment

D9248 Non-intravenous conscious sedation

D9450 Case presentation, detailed and extensive treatment planning

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FL52438HDI 0921
HumanaDental Prepaid HS195 Plan with Implants

D9610 Non-intravenous conscious sedation ........... $ 15.00
D9612 Therapeutic parenteral drugs, two or more administrations, different medications ........... $ 25.00
D9630 Other drugs and/or medicaments, by report ........ $ 15.00
D9910 Application of desensitizing medicament ........ $ 15.00
D9940 Occlusal guard, by report ......................... $ 85.00
D9942 Repair and/or reline of occlusal guard .......... $ 40.00
D9951 Occlusal adjustment—limited .................... $ 30.00
D9952 Occlusal adjustment—complete ................. $ 100.00

Bleaching  Member pays
D9972 External bleaching in office—per arch .......... $ 125.00
D9975 External bleaching in home—per arch .......... $ 125.00

Orthodontics  Member pays
D8070 Comprehensive orthodontic treatment of the transitional dentition .................. $1,850.00 
Consultation ........................................ no charge
Evaluation ........................................... $ 35.00
Records/treatment planning ......................... $ 250.00
D8080 Comprehensive orthodontic treatment of the adolescent dentition ................ $1,850.00 
Consultation ........................................ no charge
Evaluation ........................................... $ 35.00
Records/treatment planning ......................... $ 250.00
D8090 Comprehensive orthodontic treatment of the adult dentition ................ $1,850.00 
Consultation ........................................ no charge
Evaluation ........................................... $ 35.00
Records/treatment planning ......................... $ 250.00
D8680 Orthodontic retention .......................... $ 300.00
D8698 Re-cement or re-bond fixed retainer, maxillary ........................................... no charge
D8699 Re-cement or re-bond fixed retainer, mandibular ........................................... no charge

Implants (available for groups 10+ enrolled)
Coverage for implants:
• Implants and implant supported prostheses covered at a 50% coinsurance
• Annual Maximum Benefit of $1,500
• Lifetime Maximum Benefit of $10,000

NOTE:
• Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
• Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
• When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
• Some covered services are typically only offered by a specialist (like many oral surgery procedures)
• Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at Disclosure.Humana.com.

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Offered by CompBenefits Company.
### Plan-year deductible
(excludes orthodontia services)

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50</td>
<td>$150</td>
<td>$50</td>
<td>$150</td>
</tr>
</tbody>
</table>

Deductible applies to all services excluding preventive services.

### Plan-year annual maximum
(excludes orthodontia services)

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive services

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine oral examinations (3 per plan year)</td>
<td>100% no deductible</td>
<td>90% no deductible</td>
</tr>
<tr>
<td>Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine cleanings (3 per plan year)</td>
<td></td>
<td></td>
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<tr>
<td>Fluoride treatment (1 per year, through age 14)</td>
<td></td>
<td></td>
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<tr>
<td>Space maintainers (primary teeth, through age 14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Cancer Screening (1 per plan year, ages 40 and older)</td>
<td></td>
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</tr>
</tbody>
</table>

### Basic services

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care for pain relief</td>
<td>85% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Amalgam fillings (1 per tooth every 2 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite fillings, anterior/front teeth and molar teeth (1 per tooth every 2 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stainless steel crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful habit appliances for children (1 per lifetime, through age 14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants (permanent molars, through age 15)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Major services

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns (1 per tooth every 5 years)</td>
<td>55% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inlays/onlays (1 per tooth every 5 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridges (1 per tooth every 5 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures (1 per tooth every 5 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture relines/rebases (1 every 3 years, following 6 months of denture use)</td>
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<td></td>
</tr>
<tr>
<td>Denture repair and adjustments (following 6 months of denture use)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral surgery (tooth extractions including impacted teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants (crowns, bridges, and dentures each limited to 1 per tooth every five years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics (periodontal cleanings, 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)</td>
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</tbody>
</table>

### Orthodontia services

Child orthodontia covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $2,000 lifetime orthodontia maximum.

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1-800-233-4013 | Humana.com
Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Questions?
Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit Humana.com.
Feel good about choosing a Humana Dental plan

Make regular dental visits a priority
Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your Humana Dental PPO plan focuses on prevention and early diagnosis, providing three routine cleanings, or four periodontal cleanings, along with three routine periodic exams per calendar year.
* www.perio.org

Go to MyDentalIQ.com
Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth:
• Use a soft-bristled toothbrush
• Choose toothpaste with fluoride
• Brush for at least two minutes twice a day
• Floss daily
• Watch for signs of periodontal disease such as red, swollen, or tender gums
• Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person’s chances for career success?* Humana Dental helps you feel good about your dental health so you can smile confidently.
* American Academy of Cosmetic Dentistry

Use your Humana Dental benefits
Find a dentist
With Humana Dental’s PPO plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the Humana Dental PPO Network. To find a dentist in Humana Dental’s PPO Network, log on to Humana.com or call 1-800-233-4013.

Know what your plan covers
The other side of this page gives you a summary of Humana Dental benefits. Your plan certificate describes your Humana Dental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at Humana.com or call 1-800-233-4013.

See your dentist
Your Humana Dental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at Humana.com.

Learn what your plan paid
After Humana Dental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at Humana.com or by calling 1-800-233-4013.


This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.
Predetermination of Benefits

Predetermination of your Humana dental benefits (PPO plans only)

• If you expect to pay more than $300 for dental care, your dentist may submit a proposed dental treatment plan that Humana will use to determine if your dental benefits cover the treatment.
• This is known as “predetermination of benefits” (also called prior authorization).
• The dental treatment plan may include:
  o A list of services to be performed, including any supporting documentation
  o A written description from the dentist of the treatment
  o An itemized list of costs

Please note: It will remain valid for up to 90 days after the review, and is not a guarantee of what Humana will pay toward the treatment.
Dental Provider Search

1. **GO TO HUMANA.COM**
   - Choose “Find a dentist” under “Shop for Plans”
   - Click on the “Find a dentist” button

2. **ENTER ZIP CODE AND SELECT THE NETWORK**
   - Enter your desired zip code
   - Select “Look up by” to choose your network

3. **SELECT SEARCH CRITERIA**
   - Select Coverage Type
   - Click DHMO Network
   - From the drop down box for Networks, choose
     - HD DHMO/Pre-Paid HS195
     - Click Select (for PPO, select Traditional/Preferred)
   - Select “Category” Choose “Name,” “Specialty,” or “All”
   - Enter a provider’s Name, dental Specialty or “General” if All is selected
   - Click Search
Get access to virtual dental care 24/7 with Teledentix

When it’s urgent, you can see a dentist virtually

Humana members have access to $0 teledentistry, also known as virtual dental care, with Teledentix, as part of their Humana Dental plan. Teledentistry services allow you to see a dentist within minutes from your computer, smartphone or tablet.

If you’re in pain or cannot visit a dentist’s office, virtual dental care may be an option rather than a visit to the emergency room.

How you can use teledentistry

Typically, when you have a teledentistry visit, you will speak with a dental provider through an online video chat or a phone call. You can get access to care from the comfort of your home for a variety of dental needs. Teledentix dentists can:

- Write prescriptions for antibiotics or non-narcotic pain medications when needed (Please note, the cost of medications are not covered by your dental plan.)
- Perform a visual exam for things like mouth, tooth or jaw pain
- Provide instructions on caring for mouth, tooth or jaw pain
- Help members determine if they need urgent/emergency care or home care until they can see their dentist
- Help members find a dentist if they don’t have one or if requested

Tips to prepare for your Teledentix virtual dental visit

1. Register on the Teledentix app, or from your computer at Humana.teledentix.com/c/humanaondemand.
2. Fill out any required patient forms before your appointment.
3. Make a list of any symptoms, questions or concerns in advance, so you’ll be ready to discuss them with your provider.
4. Share any prescriptions, over-the-counter medicines or supplements you’re currently taking with your provider. If you have a preferred pharmacy, have the name and address handy in case your provider suggests prescription medication.

To learn more about teledentistry or your Humana Dental benefits, visit Humana.com. Available for PPO/Traditional Preferred plans only

Teledentistry is not available in all states. Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply. Teledentistry services are available on-demand or by appointment to members of all ages, including children and adolescents. Internet access is required for video teledentistry visits. Data fees may apply.

Available on PPO and Traditional Preferred plans only.
Dental PPO plans are not offered in all states.

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.

For California: Covered services provided via telehealth are also available on an in-person basis at an in-network or out-of-network provider of your choice, although selection of an out-of-network provider may result in a higher cost sharing obligation for you. In-network providers will not balance bill you for covered services you receive. Acceptance of covered services from a third-party telehealth provider and submission of claims will serve as consent to the terms of service provided in this notice.
### Humana Vision Exam Plus Low Option

#### Vision care services

<table>
<thead>
<tr>
<th></th>
<th>If you use an IN-NETWORK provider (Member cost)</th>
<th>If you use an OUT-OF-NETWORK provider (Reimbursement)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam with dilation as necessary</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retinal imaging ¹</td>
<td>$0</td>
<td>Up to $30</td>
</tr>
<tr>
<td></td>
<td>Up to $39</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Contact lens exam options ²</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standard contact lens fit and follow-up</td>
<td>Up to $40</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Premium contact lens fit and follow-up</td>
<td>10% off retail</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Frames ³</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35% off retail</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Standard plastic lenses ⁴</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single vision</td>
<td>$50</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$70</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>$105</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Lenticular</td>
<td>20% off retail</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Covered lens options ⁴</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UV Coating</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Tint (solid and gradient)</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard scratch-resistance</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard polycarbonate - adults</td>
<td>$40</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard polycarbonate - children &lt;19</td>
<td>$40</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard anti-reflective coating</td>
<td>$45</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard progressive (add-on to bifocal)</td>
<td>$65</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Polarized</td>
<td>20% off retail</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Contact lenses ⁵</strong> (applies to materials only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conventional</td>
<td>15% off retail</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Disposable</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Medically necessary</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Examination</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>• Lenses or contact lenses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Frame</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

¹ Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

² Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

³ Discounts may be available on all frames except when prohibited by the manufacturer.

⁴ Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

⁵ Plan covers contact lenses or frames, but not both.
Humana Vision Exam Plus

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider’s professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Questions?

Check out Humana.com
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.
Limitations and Exclusions:
In addition to the limitations and exclusions listed in your “Vision Benefits” section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker’s compensation or occupational disease act or law, whether or not you applied for coverage.
2. 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); or
   • Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. 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.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   • Is not a visual necessity;
   • Does not offer a favorable prognosis;
   • Does not have uniform professional endorsement; or
   • Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Any vision materials.
21. Any examination or material required by an Employer as a condition of employment.


This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.
# Vision care services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>IN-NETWORK Provider (Member cost)</th>
<th>OUT-OF-NETWORK Provider (Reimbursement)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam with dilation as necessary</strong></td>
<td>$10</td>
<td>Up to $30</td>
</tr>
<tr>
<td>• Retinal imaging 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Up to $39</td>
<td></td>
</tr>
<tr>
<td><strong>Contact lens exam options 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standard contact lens fit and follow-up</td>
<td>Up to $40</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Premium contact lens fit and follow-up</td>
<td>10% off retail</td>
<td></td>
</tr>
<tr>
<td><strong>Frames 3</strong></td>
<td>$130 allowance</td>
<td>$65 allowance</td>
</tr>
<tr>
<td>20% off balance over $130</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standard plastic lenses 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single vision</td>
<td>$15</td>
<td>Up to $25</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$15</td>
<td>Up to $40</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>$15</td>
<td>Up to $60</td>
</tr>
<tr>
<td>• Lenticular</td>
<td>$15</td>
<td>Up to $100</td>
</tr>
<tr>
<td><strong>Covered lens options 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UV coating</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Tint (solid and gradient)</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard scratch-resistance</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard polycarbonate - adults</td>
<td>$40</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard polycarbonate - children &lt;19</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard anti-reflective coating</td>
<td>$45</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Premium anti-reflective coating</td>
<td>Premium anti-reflective coatings as follows:</td>
<td>Premium anti-reflective coatings as follows:</td>
</tr>
<tr>
<td>– Tier 1</td>
<td>$57</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Tier 2</td>
<td>$68</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Tier 3</td>
<td>80% of charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard progressive (add-on to bifocal)</td>
<td>$15</td>
<td>Up to $40</td>
</tr>
<tr>
<td>• Premium progressive</td>
<td>Premium progressives as follows:</td>
<td>Premium progressives as follows:</td>
</tr>
<tr>
<td>– Tier 1</td>
<td>$110</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Tier 2</td>
<td>$120</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Tier 3</td>
<td>$135</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Tier 4</td>
<td>$90 copay, 80% of charge less $120 allowance</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Photochromatic / plastic transitions</td>
<td>$75</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Polarized</td>
<td>20% off retail</td>
<td></td>
</tr>
<tr>
<td><strong>Contact lenses 5</strong> (applies to materials only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conventional</td>
<td>$135 allowance,</td>
<td>$135 allowance</td>
</tr>
<tr>
<td></td>
<td>15% off balance over $135</td>
<td></td>
</tr>
<tr>
<td>• Disposable</td>
<td>$135 allowance</td>
<td>$135 allowance</td>
</tr>
<tr>
<td>• Medically necessary</td>
<td>$0</td>
<td>$200 allowance</td>
</tr>
</tbody>
</table>
**Vision care services**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>If you use an IN-NETWORK provider (Member cost)</th>
<th>If you use an OUT-OF-NETWORK provider (Reimbursement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examination</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>• Lenses or contact lenses</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>• Frame</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>

**Diabetic Eye Care: care and testing for diabetic members**

<table>
<thead>
<tr>
<th>Test Type</th>
<th>IN-NETWORK (Member cost)</th>
<th>OUT-OF-NETWORK (Reimbursement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination - Up to (2) services per year</td>
<td>$0</td>
<td>Up to $77</td>
</tr>
<tr>
<td>Retinal Imaging - Up to (2) services per year</td>
<td>$0</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Extended Ophthalmoscopy - Up to (2) services per year</td>
<td>$0</td>
<td>Up to $15</td>
</tr>
<tr>
<td>Gonioscopy - Up to (2) services per year</td>
<td>$0</td>
<td>Up to $15</td>
</tr>
<tr>
<td>Scanning Laser - Up to (2) services per year</td>
<td>$0</td>
<td>Up to $33</td>
</tr>
</tbody>
</table>

**Optional benefits**

- 12-month Frame Benefit
- Polycarbonate Lenses for Children <19

Benefit replaces the 24-month frequency of the base plan. Provides for standard polycarbonate lens with $0 copay. Not available in AK, CT, ID, & OH.

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2. Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
3. Discounts may be available on all frames except when prohibited by the manufacturer.
4. Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
5. Plan covers contact lenses or frames, but not both.
Humana Vision 130

**Additional plan discounts**

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Questions?
Check out [Humana.com](http://Humana.com)
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.
How to find a network vision provider

1. Choose “Find an eye doctor” under “Shop for Plans”
2. Click on the “Find an eye doctor” button

SELECT

“Humana Vision/Humana Extend (Humana Insight Network)”

SELECT SEARCH CRITERIA

1. Enter desired zip code
2. Click “Get Results”

Find a network provider near you by searching below. To find a participating provider, complete either the full street address or the zip code, then click Search. Always call ahead to confirm a provider’s participation in your plan. Make sure to say you’re a Humana Vision member to ensure you receive your maximum benefits. Not all providers participate in every plan. If you aren’t yet enrolled in a Humana Vision plan, please keep in mind your actual network may vary from what appears on our locator.
See a brighter future with contacts delivered straight to your door

Humana members, meet ContactsDirect

We know life gets busy. You don’t always have time to visit your eye doctor to pick up new contact lenses. With ContactsDirect, you don’t have to. ContactsDirect is an in-network service that delivers contact lenses straight to your door. That’s human care.

As a Humana member, you can apply your vision benefits directly to the contacts you buy through ContactsDirect. Choose from dozens of the name brands you know and love and have them shipped to you for free.

ContactsDirect.com is just another way Humana is helping you see a brighter future.

How to order your new contacts:

2. Choose from a wide selection of top selling brands.
3. In-network vision benefits instantly apply to your purchase price.
4. Contact lenses will ship as soon as the prescription is verified. Most even ship that same day.

Check out this new, online in-network benefit

Visit us at www.contactsdirect.com
A fresh look at glasses

Humana members, meet Glasses.com

Get new glasses from the comfort of your own home. With your Humana Vision plan, you can search thousands of options on Glasses.com and have them shipped right to you. That’s human care.

Here’s how it works:

• Search for a pair you love from thousands of name-brand frames
• Experience the photorealistic and geometrically accurate 3D virtual “try-on” app for iPad and iPhone
• Snap and send a picture of your prescription—or have Glasses.com call the provider for it
• Select lenses suited for many types of prescriptions (including progressives and multifocals)
• Get your glasses shipped the following day—with free shipping.

We’ll send you frames you like with lenses in your prescription
Test your frames up to 15 days
Keep them or send them back — all with free shipping

Buy new glasses from the comfort of home
Download the app or visit Glasses.com today

Humana
Your personal MyHumana account gives you quick, convenient and secure access to your Humana vision plan information. It's available anytime, anywhere.

Get quick access to your vision plan

View, print and email ID cards

Check your claim status

Review deductibles, coverage levels and limits

Find an eye doctor near you

A dashboard that puts all your information in one spot

Chat with a representative about any of your vision plan questions

Registering is easy

1. Go to Humana.com/register and “Start activation now”.
2. Confirm member information. Enter your member ID number (or Social Security number), date of birth and ZIP code.
3. Create a username, password and security prompt and click “Next” to finish.

Use MyHumana anywhere

Download the MyHumana Mobile app from your app store. You can also sign up for text message alerts* at Humana.com.

* Message and data rates may apply
At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call 877-320-1235 or if you use a TTY, call 711.


- California residents: You may also call California Department of Insurance toll-free hotline number: 800-927-HELP (4357), to file a grievance.

**Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

**Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)**

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi):
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani’í bee wolta’íigíí bich’íí hödíílníh éí bee t’áá jiik’eh saad bee áká’ánída’áwo’déé níká’adoowól.
العربيّة (Arabic):
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك.