Humana®

Humana/CompBenefits

CITY OF LAKELAND

DENTAL OPTIONS

Humana®

YOU HAVE A CHOICE OF FOUR PLANS - SELECT ONE!

Choice One Managed Care/DHMO Dental Plan	Choice Two PPO/INDEMNITY-MID w/Ortho Dental Plan	Choice Three PPO/Indemnity w/Ortho Dental Plan	Choice Four Dental Plan-Advantage 1S Plan
• Provider Assignment required, choose DHMO Network Provider • No Hidden costs or referrals needed to see Specialists • No annual maximums or limitations • No waiting periods • No Deductibles • No Claim Forms • Adult & Child(ren) Ortho • After $5 office visit copayment, the dentist selected will perform most Preventative and Diagnostic procedures at no charge • Members receive a 25% discount for procedures not listed on Schedule of Benefits • Participation Specialists paid according to Schedule of Benefits; same as general dentist	• Choose any dentist; however greater savings when you access a Network Provider • Annual deductible In & Out of Network $50 /3 per family • $1, 000 Annual Maximum • No Waiting Periods • Claim forms • Orthodontic Coverage for Children to age 19	• Choose any dentist; however greater savings when you access a Network Provider • Annual deductible $25 (In Network) $50 (Out of Network) /3 per family • $1, 250 Annual Maximum • No Waiting Periods • Claim forms • Orthodontic Coverage for Children to age 19	• No Assignment required, however must see Advantage Network Provider • No Hidden costs or referrals needed to see Specialists • No annual maximums or limitations • No waiting periods • No Deductibles • No Claim Forms • Adult & Child(ren) Ortho • Lab fee included in Copays for Crown, Bridge, & Prosthodontics • $0 office visit copayment, the dentist selected will perform most Preventative and Diagnostic procedures at no charge • Members receive a 20% discount for procedures not listed on Schedule of Benefits • Participation Specialists paid according to Schedule of Benefits; same as general dentist

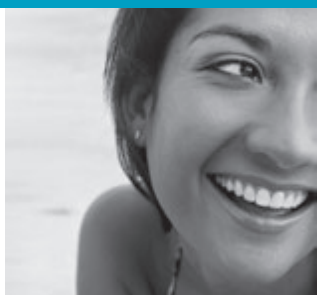
Choice One	
Employee	$12.28
Employee + One Dependent	$23.16
Employee + Two or More Dependent	$31.34

Choice Two	
Employee	$24.32
Employee + One Dependent	$42.88
Employee + Two or More Dependent	$66.84

Choice Three	
Employee	$31.00
Employee + One Dependent	**$54.64**
Employee + Two or More Dependent	$85.10

Choice Four	
Employee	$18.70
Employee + One Dependent	$36.48
Employee + Two or More Dependent	$62.08

cs series



Get More for Your Money

What to expect from your dental plan:

Think about this: Your dentist tells you that you need a complicated dental procedure best performed by a specialist. Would you have the resources to keep that appointment?

CompBenefits' CS Series dental plan makes that decision a lot easier. The CS Series provides you the opportunity to visit any of the General Dentists in our network as well as the alternative of seeing a network Specialist Dentist to complete these intricate procedures.

Your CompBenefits' CS Series dental plan also provides you with routine cleanings and x-rays every six months, topical fluoride for children up to 16 and local anesthesia, among others.

With our exhaustive schedule of benefits, you will know up front how much your co-payment will be, and for procedures that may not be listed on the CS Series schedule, you'll receive a 25 percent discount off a network dentist's usual fees.

Additionally, CompBenefits' CS Series gives you freedom from deductibles, claim forms, waiting periods, or benefit maximums.

Get more out of your dental plan @ www.mycompbenefits.com

Need to find a dentist closer to you? You can do all of this and more at www.mycompbenefits.com. Registering for this service is simple and will give you access to your plan benefits, including your benefit information, a list of providers and the option to change your account information. Just a few clicks of the mouse, and you'll be checking out your benefits in no time.

Choice One

Rates - CS150	Monthly
Employee	$12.28
Employee + 1 Dependent	$23.16
Employee + 2 or more Dependents	$31.34

Humana®

frequently asked questions

Q. *What are CS Series DHMO plans?*

A. CompBenefits' CS Series DHMO plans are network-based products that emphasize prevention and cost containment. In order to receive services, you select a primary dentist who participates in the CompBenefits DHMO network. The plan provides for quality care and allows members to seek care from in-network specialty dentist at fixed co-payments. These plans provide savings ranging from 20 percent to 60 percent off regular dental procedures. The plans do not cover services (except emergency care) received from out-of-network dentists.

Q. *How does the plan work?*

A. Your primary dentist will provide all of your routine dental care. When you visit your primary care dentist, simply present your CompBenefits identification card. You may be required to pay a co-payment for some services provided by your primary care dentist. If the dental services provided are not listed as covered procedures under the plan, primary care dentists will give you a 25 percent discount off their usual fees. Should you require the services of a specialty dentist, you can choose any in-network specialty dentist under the CompBenefits DHMO plan. All in-network specialists will provide services at the co-payment listed on your schedule of benefits. The co-payments are billed by the participating dentist at the time of service, so there are no claims forms to file. You pay your dentist directly, if applicable.

Q. *How many times a year can I visit my dentist?*

A. You are encouraged to visit your dentist regularly. With your CompBenefits' CS Series Plan, you are not limited to a specific number of visits per year.

Q. *How do I make appointments?*

A. Making an appointment is easy. Once you have selected your participating dentist, simply call the dental office on or after the date you receive your certificate of coverage and make your appointment. Your enrollment information will already be at or on its way to your participating dentist's office, confirming that you are eligible for treatment.

Q. *What if I need a specialty dentist?*

A. When you need treatment from a specialty dentist you can visit one of the participating specialty dentists from our network, and you will only be responsible for the co-payment listed on your schedule of benefits.

Q. *Is there any maximum coverage limitation?*

A. No, there are no maximum coverage limitations.

Q. *How do I pay for services?*

A. You make your co-payments to the dentist at time of service.

Q. *What if I go to a non-participating dentist?*

A. You will not be eligible for benefits from a non-participating dentist. You must seek treatment from the participating dentist you selected.

Q. *Can I change participating dentists?*

A. Yes. You can easily change dentists by contacting our Customer Care department at 800-342-5209. You can also change your dentist by logging onto www.mycompbenefits.com.

Q. *Can I go online to find out more about my plan or get assistance?*

A. Yes. You can visit www.mycompbenefits.com to learn about your plan, to check your benefits, to use our Provider Locator, to change your dentist selection, to send us an e-mail and more.

Q. *How do I order an ID card?*

A. You can download and print a temporary ID card or order a new ID card at www.mycompbenefits.com, or you can call our Customer Care department at 800-342-5209.

schedule of benefits and subscriber copayments

ADA CODE	PROCEDURE	PATIENT PAYS
APPOINTMENTS		
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$15.00
9430	Office Visit (normal hours)	$5.00
9440	Office Visit (after regularly scheduled hours)	$35.00
9999	Emergency visit during regularly scheduled hours, by report	$20.00
9999	Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies	$10.00
DIAGNOSTIC		
120	Periodic oral evaluation	NO CHARGE
140/150/160	Limited/Comprehensive oral evaluation	NO CHARGE
180	Comprehensive periodontal evaluation - new or established patient	$10.00
210	X-Ray Intraoral - complete series including bitewings	NO CHARGE
220	X-Ray Intraoral - periapical - first film	NO CHARGE
230	X-Ray Intraoral - periapical - each additional film	NO CHARGE
270	X-Ray Bitewing - single film	NO CHARGE
272	X-Ray Bitewings - two films	NO CHARGE
274	Bitewings - four films	NO CHARGE
330	Panoramic film	NO CHARGE
460	Pulp vitality tests	NO CHARGE
470	Diagnostic casts	NO CHARGE
PREVENTIVE CARE		
1110/1120	Prophylaxis-adult/child-routine (once every 6 months)	NO CHARGE
1110/1120	Prophylaxis-adult/child-(additional)	$20.00
1201	Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE
1203	Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE
1330	Oral hygiene instruction	NO CHARGE
1351	Sealant - per tooth	$10.00
1510	Space Maintainer - fixed - unilateral	$45.00 + LAB
1515	Space Maintainer - fixed - bilateral	$45.00 + LAB
1520	Space Maintainer - removable - unilateral	$85.00 + LAB
1525	Space Maintainer - removable - bilateral	$85.00 + LAB
1550	Recementation of space maintainer	$10.00
RESTORATIVE		
2140	Amalgam - one surface, primary or permanent	NO CHARGE
2150	Amalgam - two surfaces, primary or permanent	NO CHARGE
2160	Amalgam - three surfaces, primary or permanent	NO CHARGE
2161	Amalgam - four or more surfaces, primary or permanent	NO CHARGE
2940	Sedative filling	$15.00
2999	Sedative base (under fillings), by report	NO CHARGE
RESIN RESTORATION		
2330	Resin - one surface, anterior	$35.00
2331	Resin - two surfaces, anterior	$40.00
2332	Resin - three surfaces, anterior	$50.00
2391	Resin - based composite - one surface, posterior	$60.00
2392	Resin - based composite - two surfaces, posterior	$80.00
2393	Resin - based composite - three surfaces, posterior	$100.00
2394	Resin - based composite - four or more surfaces, posterior	$120.00
2510	Inlay - metallic - one surface	$95.00
2520	Inlay - metallic - two surfaces	$105.00
2530	Inlay - metallic - three or more surfaces	$130.00
CROWN & BRIDGE		
2740	Crown - porcelain/ceramic substrate	$280 + LAB
2750*	Crown - porcelain fused to high noble metal	$280.00
2751	Crown - porcelain fused to predominantly base metal	$280.00
2752*	Crown - porcelain fused to noble metal	$280.00
2790*	Crown - full cast high noble metal	$280.00

schedule of benefits and subscriber copayments

ADA CODE	PROCEDURE	PATIENT PAYS
CROWN & BRIDGE (cont.)		
2791	Crown - full cast predominantly base metal	$280.00
2792*	Crown - full cast noble metal	$280.00
2910	Recement inlay	$15.00
2920	Recement crown	$15.00
2930	Prefabricated stainless steel crown - primary tooth	$75.00
2950	Core buildup, including any pins	$45.00
2951	Pin retention - per tooth	$15.00
2952	Cast post and core in addition to crown	$90.00 + LAB
2953	Each additional cast post - same tooth	$90.00 + LAB
2954	Prefabricated post and core in addition to crown	$90.00
2962	Labial veneer (porcelain laminate) - laboratory	$280 + LAB
ENDODONTICS		
3220	Therapeutic pulpotomy	$35.00
3221	Pulpal debridement, primary and permanent teeth	$100.00
3310	Root canal therapy - anterior (excluding final restoration)	$100.00
3320	Root canal therapy - bicuspid (excluding final restoration)	$200.00
3330	Root canal therapy - molar (excluding final restoration)	$250.00
3410	Apicoectomy/periradicular surgery - anterior	$125.00
PERIODONTICS (Gum treatment)		
4210	Gingivectomy/gingivoplasty 4+ teeth per quad	$125.00
4211	Gingivectomy/gingivoplasty 1-3 teeth per quad	$40.00
4260	Osseous surgery, 4+ teeth, per quad	$350.00
4261	Osseous surgery, 1-3 teeth, per quad	$350.00
4271	Free soft tissue graft procedure (inc. donor site surgery)	$225.00
4341	Periodontal scaling and root planing 4+ teeth per quad	$50.00
4342	Periodontal scaling and root planing 1-3 teeth per quad	$50.00
4355	Full mouth debridement to enable eval and diagnosis	$45.00
PERIODONTICS (Gum treatment) (cont.)		
4381	Localized delivery of chemotherapeutic agents (per tooth)	$45.00
4910	Periodontal maintenance	$50.00
PROSTHODONTICS		
5110	Complete denture - maxillary	$300.00 + LAB
5120	Complete denture - mandibular	$300.00 + LAB
5130	Immediate denture - maxillary	$300.00 + LAB
5140	Immediate denture - mandibular	$300.00 + LAB
5211	Maxillary partial denture - resin base	$300.00 + LAB
5212	Mandibular partial denture - resin base	$300.00 + LAB
5213	Maxillary partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5214	Mandibular partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5410	Adjust complete denture - maxillary	$15.00
5411	Adjust complete denture - mandibular	$15.00
5421	Adjust partial denture - maxillary	$15.00
5422	Adjust partial denture - mandibular	$15.00
REPAIRS TO PROSTHETICS		
5510	Repair broken complete denture base	$15.00 + LAB
5520	Replace missing or broken teeth - complete denture (each tooth)	$15.00 + LAB
5610	Repair resin denture base	$15.00 + LAB
5630	Repair or replace broken clasp	$15.00 + LAB
5640	Replace broken teeth - per tooth	$15.00 + LAB
5650	Add tooth to existing partial denture	$30.00 + LAB
5730	Reline complete maxillary denture (chairside)	$50.00
5731	Reline complete mandibular denture (chairside)	$50.00
5740	Reline maxillary partial denture (chairside)	$50.00
5741	Reline mandibular partial denture (chairside)	$50.00
5750	Reline complete maxillary denture (laboratory)	$35.00 + LAB
5751	Reline complete mandibular denture (laboratory)	$35.00 + LAB
5760	Reline maxillary partial denture (laboratory)	$35.00 + LAB

schedule of benefits and subscriber copayments

ADA CODE	PROCEDURE	PATIENT PAYS
REPAIRS TO PROSTHETICS (cont.)		
5761	Reline mandibular partial denture (laboratory)	$35.00 + LAB
5850	Tissue conditioning - maxillary	$30.00
5851	Tissue conditioning - mandibular	$30.00
PROSTHODONTICS (Fixed)		
6210*	Pontic - cast high noble metal	$280.00
6211	Pontic - cast predominantly base metal	$280.00
6212*	Pontic - cast noble metal	$280.00
6240*	Pontic - porcelain fused to high noble metal	$280.00
6241	Pontic - porcelain fused to predominantly base metal	$280.00
6242*	Pontic - porcelain fused to noble metal	$280.00
6750*	Crown - porcelain fused to high noble metal	$280.00
6751	Crown - porcelain fused to predominantly base metal	$280.00
6752*	Crown - porcelain fused to noble metal	$280.00
6790*	Crown - full cast high noble metal	$280.00
6791	Crown - full cast predominantly base metal	$280.00
6792*	Crown - full cast noble metal	$280.00
6930	Recement fixed partial denture (per unit)	$10.00
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY		
7111	Coronal remnants, deciduous tooth	NO CHARGE
7140	Extraction, erupted tooth or exposed root	NO CHARGE
7210	Surgical removal of erupted tooth	$40.00
7220	Removal of impacted tooth - soft tissue	$50.00
7230	Removal of impacted tooth - partially bony	$70.00
7240	Removal of impacted tooth - completely bony	$85.00
7250	Surgical removal of residual tooth roots	$35.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	$35.00
7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$35.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	$70.00
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY (cont.)		
7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
7510	Incision and drainage of abscess - intraoral	$25.00
ORTHODONTICS		
8070/8080	Comprehensive orthodontic treatment of the transitional/adolescent dentition. Children up to 19 years of age Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
	Consultation	NO CHARGE
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic Treatment	$1,800.00
8090	Comprehensive orthodontic treatment of the adult dentition. Adults 19 years of age and over Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
	Consultation	NO CHARGE
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic Treatment	$2,000.00
8680	Retention	$450.00
ADJUNCTIVE GENERAL SERVICES		
9215	Local anesthesia	NO CHARGE
9230	Analgesia (nitrous oxide - per 15 minutes)	$15.00
9450	Case presentation, detailed and extensive treatment planning	NO CHARGE
9951	Occlusal adjustment - limited	$25.00
9952	Occlusal adjustment - complete	$150.00

* THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL. THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.

schedule of benefits and subscriber copayments

NOTE:

1. NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.
2. UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.
3. WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.

SPECIALIST SERVICES

Should you need a specialist, (i.e., Endodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Copayment amounts are applicable when treatment is performed by Participating Specialists. Benefits for procedures not listed on the schedule, that are performed by a Participating Specialist, are available at the Participating Specialist's usual and customary fee less 25%.

LIMITATIONS AND EXCLUSIONS

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph C of the Certificate.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Company does not provide coverage for the following services:
   a) Cost of hospitalization and pharmaceuticals, drugs or medications.
   b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.
   f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.
   g) Treatment for cysts, neoplasms and malignancies.
   h) General anesthesia.

elite preferred

Dental Plan of Choice

What to expect from your dental plan:

When you're experiencing tooth pain, you can rest assured that your CompBenefits PPO dental insurance will give you the peace of mind that it will be there for you, helping with the expense of that trip to the dentist.

CompBenefits' fully insured PPO emphasizes preventive care – routine oral examinations, cleanings and x-rays – the simplest way to keep those nasty toothaches away.

And you'll get these benefits at an affordable price whether you choose a dentist from one of CompBenefits' participating dental office locations or if you choose a dentist who is not in our network.

If you need to file a claim, CompBenefits will reimburse you from our state-of-the-art claims system that pays claims quickly and correctly.

Get more out of your dental plan @ www.mycompbenefits.com

Want to know the status of a claim? Need to find a dentist closer to you? You can do all of this and more at www.mycompbenefits.com. Registering for this service is simple and will give you access to your plan benefits, including your benefit information, claims status, a list of providers and the option to change your account information. Just a few clicks of the mouse, and you'll be checking out your benefits in no time.

	Choice Two ***EP620 w/Ortho-MID Plan***	***Choice Three*** ***EP620 w/Ortho***
Rates - PPO	Monthly	Monthly
Employee	**$24.32**	**$31.00**
Employee + 1 Dependent Employee	**$42.88**	**$54.64**
+ 2 or more Dependents	**$66.84**	**$85.10**

Humana®

frequently asked questions

Q. *How does an Elite Preferred dental plan work?*

A. Under our PPO plans, you do not have to pre-select a primary dentist. When you want dental services, make your appointment with any licensed dentist. When you receive treatment from a CompBenefits PPO dentist, your costs will be reduced. Once services are performed, you or your dentist must file a claim form in order to receive reimbursement. Your claim will be paid based on your group's schedule of benefits. The plan will pay a percentage of the eligible charges, up to the plan's annual limit for benefits.

Q. *How do I select an in-network dentist?*

A. You may choose a participating PPO general dentist from our preferred provider directory available online at www.mycompbenefits.com. Participating general dentists in our network are conveniently located near your home or office. CompBenefits reviews each participating dentist's credentials before he or she is selected to join our network. By using an in-network dentist, you will receive the maximum benefit of your plan.

Q. *How do I select an out-of-network dentist?*

A. By choosing a general dentist not included in the preferred provider list at www.mycompbenefits.com, you have selected an out-of-network provider. You will be charged the dentist's usual fees for treatment. When you use an out-of-network dentist, your out-of-pocket costs will be typically greater than using an in-network dentist.

Q. *When is predetermination required?*

A. If planned treatment is going to cost more than $200, you should ask your dentist to file for predetermination of benefits prior to treatment. Predetermination is not necessary for emergency treatment.

Q. *How does my bill get paid?*

A. Each dentist bills separately. Your dentist may agree to file your insurance claim for you. If he or she does not, however, you may be required to pay the entire bill at time of service and will need to submit a claim to CompBenefits for your reimbursement. Your reimbursement will be based on whether you have met any applicable deductible or coinsurance amounts or not. All financial arrangements concerning payment are strictly between you and your dentist and should be determined prior to treatment.

Q. *Where do I send my claims?*

A. You can get a claim form from your Group Benefits Administrator, from CompBenefits' Customer Care department or from our Web site, www.mycompbenefits.com. Mail your claim to:
Humana Specialty Benefits
P.O. Box 14283
Lexington, KY 40512-4283

Q. *Can I go online to find out more about my plan or get assistance?*

A. Yes. After you enroll, you can visit www.mycompbenefits.com to learn about your plan, to check your benefits, to use our Provider Locator, to change your dentist selection, to send us an e-mail and more.

CompBenefits Insurance Company
Choice Two

Elite Preferred 620 (w/ortho) True Group MID

Because we specialize in dental, we can bring you benefits and service that other companies can't match!

➢ **QUICK CLAIMS TURNAROUND**
CompBenefits' state of the art claims center provides fast reimbursement of your claims.

➢ **ACCESS TO INFORMATION**
Our toll-free Customer Care number at 1-(800)-342-5209 has Customer Care Representatives who can provide the answers you need quickly and thoroughly.

➢ **TOTAL FREEDOM OF CHOICE**
The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

Any way you add it up, CompBenefits really is the benefits company of choice!

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Coverage based on contracted fees for the Preferred Provider Network.

**Time served on the employer's immediately preceding group dental plan may be credited towards this plan's waiting periods, subject to Underwriting approval.

***Maximum of 3 per family.

SUMMARY OF BENEFITS

Partial Listing of Covered Services	In-Network Reimbursements	Out-of-Network Reimbursements

Type I Diagnostic & Preventive…100%……..……80%
Oral Examination (once per six months)
Prophylaxis (cleaning, once per six months)
Topical Fluoride (children under 16, once per 12 months)
X-Rays (limitations may apply)
Sealants (once per 3 years for children under age 16, for non carious molars only)
Space Maintainers (for children under age 16)

Type II Basic Services……. 80%…….60%
Simple Restorative (amalgam, synthetic, or composite fillings)
Emergency Palliative Treatment
Tooth Extraction
Endodontics (root canals)

Type III Major Services…….50%……40%
Major Restorative (crowns/inlays/onlays)
Periodontics (includes treatment of diseases of the gums
Bridge, Denture Repair
Prosthetics (bridges and dentures)

Type IV Orthodontics ……50%…….40%
Dependent children 18 years of age or younger

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III…….……Unlimited…….Unlimited	
Type IV……$1,000……...$1,000	
Calendar Year	
Type I, II, III……$1,000…….…$1,000	
Type IV……..$1,000…….…$1,000	
Deductible* **	
Type I……..……None……..None	
Type II, III, IV……$50…….……$50	

PPO True Group High – Ortho

Elite Choice 620-1

005CI620X

CompBenefits Insurance Company
Choice Three

Elite Preferred 620 (w/ortho)

Because we specialize in dental, we can bring you benefits and service that other companies can't match!

- **QUICK CLAIMS TURNAROUND**

CompBenefits' state of the art claims center provides fast reimbursement of your claims.

- **ACCESS TO INFORMATION**

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- **TOTAL FREEDOM OF CHOICE**

The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

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X-Rays (limitations may apply)		
Sealants (once per 3 years for children under age 16, for non carious molars only)		
Space Maintainers (for children under age 16)		
Type II Basic Services	**80%**	**70%**
Simple Restorative (amalgam, synthetic, or composite fillings)		
Emergency Palliative Treatment		
Tooth Extraction		
Endodontics (root canals)		
Type III Major Services	**50%**	**40%**
Major Restorative (crowns/inlays/onlays)		
Periodontics (includes treatment of diseases of the gums		
Bridge, Denture Repair		
Prosthetics (bridges and dentures)		
Type IV Orthodontics	**50%**	**40%**
Dependent children 18 years of age or younger		

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III	Unlimited
Type IV	$1,000
Calendar Year	
Type I, II, III	$1,250
Type IV	$1,000
Deductible* **	
Type I	None
Type II, III, IV	$25

PPO True Group High – Ortho

Elite Choice 620-1

005CI620X

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8. procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
18. an injury that arises out of or in the course of a job or employment for pay or profit;
19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors; or
20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

PPO True Group High – Ortho

Elite Choice 620-1

005CI620X

advantage

What to expect from your dental plan:

Life brings all manner of surprises – some of them good, some of them not.

No matter how much you plan for now and the future, it is very likely that something will come along that leaves you wondering how you are going to pay for it – like dental problems.

Your teeth may be perfectly healthy right now, but CompBenefits' Advantage plan will give you the security you need in case you are looking at expensive dental treatment down the road.

Advantage is a new generation, hybrid dental plan (which takes the best from DHMOs as well as traditional indemnity insurance). And Advantage is the dental benefit of choice for thousands of CompBenefits members who depend on a company that has been helping people maintain good oral health for more than 25 years.

Advantage isn't hard to navigate: you'll be free from deductibles, claim forms, waiting periods, and benefit maximums – freedom you won't find with other insurance plans.

Plus, you'll get a large network of in-network dentists, and with a small co-payment, routine cleanings and x-rays every six months are covered 100 percent as well as oral exams, local anesthesia and topical fluoride for children up to age 16.

The Advantage of Good Oral Health

Get more out of your dental plan @ www.mycompbenefits.com

Need to find a dentist closer to you? You can do all of this and more at www.mycompbenefits.com. Registering for this service is simple and will give you access to your plan benefits, including your benefit information, claims status, a list of providers and the option to change your account information. Just a few clicks of the mouse, and you'll be checking out your benefits in no time.

Choice Four
Dental Plan - Advantage 1S Plan

Rates	Monthly
Employee	**$18.70**
Employee + 1 Dependent Employee	**$36.48**
+ 2 or more Dependents	**$62.08**

SSADV

Humana®

ANNUAL MAXIMUM (excludes Orthodontics): See Plan Summary Description
WAITING PERIOD–Major Services: See Plan Summary Description

Co-payment amounts for listed procedures are applicable at either the Participating General Dentist or Participating Specialist.

schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
PREVENTIVE SERVICES		
D0120	Periodic oral examination (limit 1 every 6 months)	$0.00
D0140	Limited oral evaluation - problem focused (limit 1 every 6 months)	$0.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver (limit 1 every 12 months)	$0.00
D0150	Comp oral evaluation - new/established patient (limit 1 every 24 months)	$0.00
D0160	Dtl&Ext oral evaluation - problem focused report (limit 1 every 12 months)	$0.00
D0170	Re-evaluation - limited problem focused (limit 1 every 12 months)	$0.00
D0180	Comp periodontal evaluation - new/est patient (limit 1 every 24 months)	$0.00
D0210	Intraoral-Complete series (limit 1 every 3 years)	$0.00
D0220	Intraoral-Periapical-First film (limit 9 every 12 months incl. D0230)	$0.00
D0230	Intraoral-Periapical-Each additional film (limit 9 every 12 months incl. D0220)	$0.00
D0240	Intraoral - occlusal film	$0.00
D0250	Extraoral - first film	$0.00
D0260	Extraoral - each additional film	$0.00
D0270	Bitewing - single film (limit 1 every 6 months)	$0.00
D0272	Bitewings - two films (limit 1 every 6 months)	$0.00
D0273	Bitewings - three films (limit 1 every 6 months)	$0.00
D0274	Bitewings - four films (limit 1 every 6 months)	$0.00
D0277	Vertical bitewings - 7 to 8 films (limit 1 every 6 months)	$0.00
D0330	Panoramic film (limit 1 every 3 years)	$0.00
D0470	Diagnostic casts	$0.00
D1110	Prophylaxis - adult (limit 1 every 6 months, inclusive of D4910)	$0.00
D1120	Prophylaxis - child (limit 1 every 6 months, inclusive of D4910)	$0.00
D1203	Topical application of fluoride - child (limit 1 every 6 months for child <16)	$0.00
D1206	Topical fluoride varnish (limit 1 every 6 months for child <16)	$0.00
D1351	Sealant - per tooth (limit 1 per tooth every 12 months for child <14)	$0.00

ADA CODE	PROCEDURE	PATIENT PAYS
BASIC SERVICES		
D1510	Space maintainer - fixed-unilateral (limited to child <14)	$53.00
D1515	Space maintainer - fixed-bilateral (limited to child <14)	$70.00
D1520	Space maintainer - removable-unilateral (limited to child <14)	$66.00
D1525	Space maintainer - removable-bilateral (limited to child <14)	$91.00
D1550	Recementation of space maintainer	$12.00
D2140	Amalgam-One surface primary or permanent	$24.00
D2150	Amalgam-Two surfaces primary or permanent	$31.00
D2160	Amalgam-Three surfaces primary or permanent	$37.00
D2161	Amalgam-Four/More surfaces primary/permanent	$46.00
D2330	Resin-Based composite - one surface anterior	$24.00
D2331	Resin-Based composite - two surfaces anterior	$31.00
D2332	Resin-Based composite - three surfaces anterior	$38.00
D2335	Resin compos - 4/more surfaces/invlv incisal ang	$45.00
D2390	Resin-Based composite crown anterior	$49.00
D2391	Resin-Based composite - one surface posterior	$28.00
D2392	Resin-Based composite - two surfaces posterior	$37.00
D2393	Resin-Based composite - three surfaces posterior	$46.00
D2394	Resin compos - four or more surfaces posterior	$56.00
D4341	Prdontal scaling&root planing 4/more teeth-quad (limit 1 per quad every 12 months)	$39.00
D4342	Prdontal scaling&root planing 1-3 teeth-quad (limit 1 per quad every 12 months)	$21.00
D4355	Full mouth debrid enable comp evaluation & dx (limit 1 every 5 years)	$26.00
D4910	Periodontal maintenance (limit 1 every 6 months, inclusive of D1110 and D1120)	$23.00

schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
BASIC SERVICES (cont.)		
D7111	Extraction coronal remnants deciduous tooth	$20.00
D7140	Extraction erupted tooth or exposed root	$26.00
MAJOR SERVICES		
D2510	Inlay - metallic - one surface (limit 1 per tooth every 8 years)	$313.00
D2520	Inlay - metallic - two surfaces (limit 1 per tooth every 8 years)	$355.00
D2530	Inlay - metallic - 3 or more surfaces (limit 1 per tooth every 8 years)	$410.00
D2542	Onlay - metallic - two surfaces (limit 1 per tooth every 8 years)	$402.00
D2543	Onlay metallic three surfaces (limit 1 per tooth every 8 years)	$420.00
D2544	Onlay metallic 4 or more surfaces (limit 1 per tooth every 8 years)	$437.00
D2610	Inlay - porcelain/ceramic - one surface (limit 1 per tooth every 8 years)	$368.00
D2620	Inlay - porcelain/ceramic - 2 surfaces (limit 1 per tooth every 8 years)	$389.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces (limit 1 per tooth every 8 years)	$414.00
D2642	Onlay - porcelain/ceramic - two surfaces (limit 1 per tooth every 8 years)	$403.00
D2643	Onlay - porcelain/ceramic - three surfaces (limit 1 per tooth every 8 years)	$434.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces (limit 1 per tooth every 8 years)	$461.00
D2650	Inlay - resin based composite - 1 surface (limit 1 per tooth every 8 years)	$242.00
D2651	Inlay - resin based composite - 2 surfaces (limit 1 per tooth every 8 years)	$288.00
D2652	Inlay - resin based compos - 3/more surfaces (limit 1 per tooth every 8 years)	$303.00
D2662	Onlay - resin based compos - 2 surfaces (limit 1 per tooth every 8 years)	$263.00
D2663	Onlay - resin based compos - 3 surfaces (limit 1 per tooth every 8 years)	$310.00
D2664	Onlay - resin based compos - 4/ more surfaces (limit 1 per tooth every 8 years)	$332.00
MAJOR SERVICES (cont.)		
D2710	Crown resin based composite indirect (limit 1 per tooth every 8 years)	$187.00
D2720	Crown - resin with high noble metal (limit 1 per tooth every 8 years)	$461.00
D2721	Crown - resin with predominantly base metal (limit 1 per tooth every 8 years)	$432.00
D2722	Crown - resin with noble metal (limit 1 per tooth every 8 years)	$441.00
D2740	Crown - porcelain/ceramic substrate (limit 1 per tooth every 8 years)	$473.00
D2750	Crown - porcelain fused to high noble metal (limit 1 per tooth every 8 years)	$466.00
D2751	Crown - porcelain fused predom base metal (limit 1 per tooth every 8 years)	$434.00
D2752	Crown - porcelain fused to noble metal (limit 1 per tooth every 8 years)	$445.00
D2790	Crown - full cast high noble metal (limit 1 per tooth every 8 years)	$450.00
D2791	Crown - full cast predom base metal (limit 1 per tooth every 8 years)	$426.00
D2792	Crown - full cast noble metal (limit 1 per tooth every 8 years)	$434.00
D2910	Recement inlay onlay/part coverage restoration	$41.00
D2920	Recement crown	$42.00
D2930	Prefabr stainless steel crown - primary tooth	$115.00
D2931	Prefabr stainless steel crown - permanent tooth	$131.00
D2932	Prefabricated resin crown	$142.00
D2940	Sedative filling	$44.00
D2950	Core buildup including any pins	$110.00
D2951	Pin retention - per tooth addition restoration	$23.00
D2952	Cast post and core in addition to crown	$168.00
D2954	Prefabricated post and core in addition to crown	$139.00
D3220	Tx pulp-remove pulp coronal dentinocementl junc	$75.00
D3310	Anterior root canal	$315.00
D3320	Bicuspid root canal	$385.00
D3330	Molar root canal	$497.00
D3346	Retreatment previous rc therapy - anterior	$424.00
D3347	Retreatment previous rc therapy - bicuspid	$500.00
D3348	Retreatment previous root canal therapy - molar	$601.00
D3410	Apicoectomy/Periradicular surgery - anterior	$361.00

schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
MAJOR SERVICES (cont.)		
D3421	Apicoectomy/Periradicular surgery - bicuspid	$394.00
D3425	Apicoectomy/Periradicular surgery - molar	$445.00
D3426	Apicoectomy/Periradicular surgery	$148.00
D3430	Retrograde filling - per root	$109.00
D4210	Gingivect/Plsty 4/>cntig/bound teeth spaces-quad (limit 1 every 12 months)	$358.00
D4211	Gingivect/Plsty 1-3 cntig/bound teeth space-quad (limit 1 every 12 months)	$153.00
D4240	Gingl flp proc 4/> contig/bound teeth space-quad (limit 1 every 12 months)	$421.00
D4241	Gingl flp proc 1-3 contig/bound teeth space-quad (limit 1 every 12 months)	$217.00
D4249	Clinical crown lengthening - hard tissue	$481.00
D4260	Osseous surg 4/> contig/bound teeth spaces-quad	$680.00
D4261	Osseous surg 1-3 contig/bound teeth spaces-quad	$354.00
D5110	Complete denture - maxillary (limit 1 every 5 years)	$642.00
D5120	Complete denture - mandibular (limit 1 every 5 years)	$642.00
D5130	Immediate denture - maxillary (limit 1 every 5 years)	$700.00
D5140	Immediate denture - mandibular (limit 1 every 5 years)	$700.00
D5211	Maxillary partial denture - resin base (limit 1 every 5 years)	$542.00
D5212	Mandibular partial denture - resin base (limit 1 every 5 years)	$629.00
D5213	Max part dentr-cast metl frmewrk w/rsn base (limit 1 every 5 years)	$709.00
D5214	Mnd part dentr- cst metl frmewrk w/rsn base (limit 1 every 5 years)	$709.00
D5410	Adjust complete denture - maxillary (limit 1 every 12 months)	$35.00
D5411	Adjust complete denture - mandibular (limit 1 every 12 months)	$35.00
D5421	Adjust partial denture - maxillary (limit 1 every 12 months)	$35.00
D5422	Adjust partial denture - mandibular (limit 1 every 12 months)	$35.00
D5510	Repair broken complete denture base	$70.00
D5520	Replace missing/broken teeth - complete denture	$59.00
D5610	Repair resin denture base	$76.00
D5620	Repair cast framework	$82.00
D5630	Repair or replace broken clasp	$100.00
D5640	Replace broken teeth - per tooth	$64.00

ADA CODE	PROCEDURE	PATIENT PAYS
MAJOR SERVICES (cont.)		
D5650	Add tooth to existing partial denture	$88.00
D5660	Add clasp to existing partial denture	$105.00
D5710	Rebase complete maxillary denture (limit 1 every 3 years)	$261.00
D5711	Rebase complete mandibular denture (limit 1 every 3 years)	$249.00
D5720	Rebase maxillary partial denture (limit 1 every 3 years)	$246.00
D5721	Rebase mandibular partial denture (limit 1 every 3 years)	$246.00
D5730	Reline complete maxillary denture (limit 1 every 3 years)	$147.00
D5731	Reline complete mandibular denture (limit 1 every 3 years)	$147.00
D5740	Reline maxillary partial denture (limit 1 every 3 years)	$135.00
D5741	Reline mandibular partial denture (limit 1 every 3 years)	$135.00
D5750	Reline complete maxillary denture (limit 1 every 3 years)	$196.00
D5751	Reline complete mandibular denture (limit 1 every 3 years)	$196.00
D5760	Reline maxillary partial denture (limit 1 every 3 years)	$193.00
D5761	Reline mandibular partial denture (limit 1 every 3 years)	$193.00
D5850	Tissue conditioning maxillary	$61.00
D5851	Tissue conditioning mandibular	$61.00
D6092	Recement implant/abutment supported crown	$42.00
D6093	Recement implant/abutment supported fixed partial denture	$57.00
D6210	Pontic - cast high noble metal (limit 1 every 8 years)	$431.00
D6211	Pontic - cast predominantly base metal (limit 1 every 8 years)	$404.00
D6212	Pontic - cast noble metal (limit 1 every 8 years)	$420.00
D6240	Pontic - porcelain fused to high noble metal (limit 1 every 8 years)	$426.00
D6241	Pontic - porceln fused predom base metl (limit 1 every 8 years)	$393.00
D6242	Pontic - porcelain fused to noble metal (limit 1 every 8 years)	$415.00
D6250	Pontic - resin with high noble metal (limit 1 every 8 years)	$420.00
D6251	Pontic - resin with predominantly base metal (limit 1 every 8 years)	$388.00
D6252	Pontic - resin with noble metal (limit 1 every 8 years)	$400.00

schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
MAJOR SERVICES (cont.)		
D6600	Inlay-Porcelain/Ceramic two surfaces (limit 1 every 8 years)	$355.00
D6601	Inlay - porcelain/ceramic 3 or more surfaces (limit 1 every 8 years)	$373.00
D6602	Inlay - cast high noble metal two surfaces (limit 1 every 8 years)	$380.00
D6603	Inlay - cast high noble metl 3/more surfaces (limit 1 every 8 years)	$418.00
D6604	Inlay - cast predom base metal 2 surfaces (limit 1 every 8 years)	$372.00
D6605	Inlay - cast predom bse metl 3/more surfaces (limit 1 every 8 years)	$394.00
D6606	Inlay - cast noble metal two surfaces (limit 1 every 8 years)	$366.00
D6607	Inlay - cast noble metal 3 or more surfaces (limit 1 every 8 years)	$406.00
D6608	Onlay - porcelain/ceramic two surfaces (limit 1 every 8 years)	$386.00
D6609	Onlay - porcelain/ceramic 3 or more surfaces (limit 1 every 8 years)	$403.00
D6610	Onlay - cast high noble metal two surfaces (limit 1 every 8 years)	$409.00
D6611	Onlay - cast high noble metal 3/ more surfaces (limit 1 every 8 years)	$448.00
D6612	Onlay - cast predom base metal 2 surfaces (limit 1 every 8 years)	$407.00
D6613	Onlay - cast predom base metl 3/ more surfces (limit 1 every 8 years)	$426.00
D6614	Onlay - cast noble metal two surfaces (limit 1 every 8 years)	$399.00
D6615	Onlay - cast noble metal 3 or more surfces (limit 1 every 8 years)	$414.00
D6720	Crown resin with high noble metal (limit 1 every 8 years)	$474.00
D6721	Crown resin w/predom base metal-denture (limit 1 every 8 years)	$450.00
D6722	Crown resin with noble metal (limit 1 every 8 years)	$458.00
D6740	Crown porcelain/ceramic (limit 1 every 8 years)	$499.00
D6750	Crown porceln fsed to hi noble metl-denture (limit 1 every 8 years)	$486.00
D6751	Crown porceln fused predom base metal (limit 1 every 8 years)	$453.00
D6752	Crown porcelain fused to noble metal (limit 1 every 8 years)	$464.00
D6780	Crown - cast high noble metal (limit 1 every 8 years)	$458.00
D6790	Crown full cast high noble metal-denture (limit 1 every 8 years)	$469.00
D6791	Crown full cast predom base metal-denture (limit 1 every 8 years)	$445.00
D6792	Crown full cast noble metal-denture (limit 1 every 8 years)	$461.00
D6930	Recement fixed partial denture (limit 1 every 5 years)	$57.00
D6970	Cast post&core add fix part dentur retainer (limit 1 every 8 years)	$157.00
D6972	Prefab post&core add fix part dentur retain (limit 1 every 8 years)	$128.00
D6973	Core build up for retainer including any pins (limit 1 every 8 years)	$103.00
D7210	Surg remv erupted tooth rqr elev flp&remv bone	$108.00
D7220	Removal of impacted tooth - soft tissue	$135.00
D7230	Removal of impacted tooth - partially bony	$179.00
D7240	Removal of impacted tooth - completely bony	$211.00
D7241	Remv imp tooth - cmpl bony w/ unusual surg comps	$265.00
D7250	Surgical removal of residual tooth roots	$114.00
D7310	Alveolplasty conjunc w/extractions-per quadrant	$125.00
D7311	Alveoloplsty conjnc xtract 1-3 teeth/ spaces quad	$97.00
D7320	Alveoloplasty not in conjunc w/ extractions-quad	$181.00
D7321	Alveoloplsty not cnjnc xtrct 1-3 teeth/ spce quad	$153.00
D7510	Incision & drainage abscess-intraoral soft tiss	$120.00
D7520	Incision & drainage abscess-extraoral soft tiss	$570.00
D7960	Frenulectomy separate procedure	$111.00
D7970	Excision of hyperplastic tissue-per arch	$272.00
D9110	Palliative treatment dental pain - minor proc	$45.00
D9215	Local anesthesia	$0.00
D9241	IV conscious sedation/analg - 1st 30 minutes	$144.00
D9242	IV conscious sedation/analg - ea add 15 minutes	$60.00
D9310	Professional consultation by non-treating dentist	$96.00
D9951	Occlusal adjustment - limited	$58.00
D9952	Occlusal adjustment - complete	$326.00

schedule of benefits and subscriber co-payments

ADA CODE	PROCEDURE	PATIENT PAYS
ORTHODONTICS		
D8070 / D8080	Comprehensive Orthodontic treatment of the transitional/adolescent dentition Children up to 19 years of age Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	$0.00
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic treatment	$2,100.00
D8090	Comprehensive Orthodontic treatment of the transitional/adult dentition Adults 19 years of age and older Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	$0.00
	Evaluation	$35.00
	Records/Treatment Planning	$250.00
	Orthodontic treatment	$2,300.00
D8680	Retention	$450.00

NOTE:

1. Your Participating General Dentist and Participating Specialist office visit co-payment amounts, if applicable, are shown on your I.D. card. Your office visit co-payment is applicable for all dates of service and is in addition to the co-payment amounts listed for Covered Dental Care Services.
2. Not all Participating Dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
3. Unlisted Covered Dental Care Services are available at the Participating Dentist's usual fee less 20%.
4. Additional exclusions and limitations are listed along with full plan information in your Certificate of Benefits.

LIMITATIONS AND EXCLUSIONS

1. Major restorative services will be subject to the following:
   a. denture, removable partial denture, or fixed partial denture must replace a natural tooth extracted while covered under this Certificate, however, this provision will not apply if the Contract replaces a prior group dental policy under which You were covered, and You are covered by this Certificate on the effective date of the Contract without a break in coverage, provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
   b. the replacement of a partial denture, full denture, or the addition of teeth to a partial denture if: (i) replacement occurs at least five years after the initial date of insertion of the current full or par-tial denture or resin bonded bridge; (ii) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (iii) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a functioning natural tooth while covered under this Certificate; or (iv) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (in-cluding a resin bonded bridge) provided the re-placement is completed within 12 months of the injury;
   c. the replacement of crowns, cast restorations, in-lays, onlays, fixed partial dentures or other laboratory prepared restora-tions only if: (i) replacement occurs at least eight years after the initial date of insertion; and (ii) they are not serviceable and cannot be res-tored to function;
   d. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition;
   e. the replacement of teeth up to the normal comple-ment of 32; and
   f. denture adjustments are limited to once every twelve (12) months starting twelve (12) months after placement.
2. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section X, Paragraph B of this Certificate.
3. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, or enjoy any of the other privileges of a Member in good standing.
4. Orthodontic treatment, if a Covered Dental Care Service as shown in the Member's Schedule of Benefits, is limited to one twenty-four (24) month course of treatment.
5. Members who are children may be seen by a Pediatric Dentist for any reason until their seventh (7th) birthday. Referrals to a Pediatric Dentist after age seven require medical documentation.
6. Only one (1) periapical radiograph is an allowed benefit for root canal treatment.
7. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.
8. Company does not provide coverage for the following services:
   a) Pharmaceuticals, drugs or medications.
   b) Services which in the opinion of the Participating General Dentist, Participating Specialist or Company are (a) not necessary; (b) not appropriate for the given condition or not customarily used for dental care; (c) do not have uniform professional endorsement or do not meet the standards set by the American Dental Association; (d) experimental or investigational in nature; (e) for which the Member has no legal obligation to pay; or (f) for which a charge would have been made in the absence of insurance.
   c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
   d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
   e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.
   f) Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability laws, or that arises out of or in the course of a job or employment for pay or profit.
   g) Treatment for cysts, neoplasms and malignancies.
   h) General anesthesia, IV sedation, and nitrous oxide, unless it is specifically listed on the Schedule of Benefits. When listed on the Schedule of Benefits, general anesthesia and IV sedation are covered only when medically necessary and provided in conjunction with other Covered Dental Services and performed by an Oral Surgeon, Periodontist, or Pediatric Dentist. The following rationales are not eligible for benefits: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.

LIMITATIONS AND EXCLUSIONS (cont.)

i) Any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company.

j) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling.

k) Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting.

l) Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite restoration, or bite analysis.

m) Adult fluoride treatments, athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instructions, radiograph duplication charges for claim submission, separate charges for acid etching, completion of claim fees, equipment or technology fees, exams required by third party, personal supplies (water pik, toothbrush, floss holder, etc.), or replacement of lost or stolen appliances.

n) Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.

o) Procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis.

p) Extraction of asymptomatic third molars, including extraction of erupted third molars for orthodontics.

q) Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). Facings on crowns or fixed partial dentures on molar teeth will always be considered cosmetic.

r) Dental implants and related services.

s) Restoration of teeth that have been damaged by attrition, abrasion, or erosion.

t) Resin bonded bridges, including associated retainers and pontics.

u) Charges for travel time, transportation costs, or professional advice given on the phone.

v) Procedures performed by a dentist who is a member of Your immediate family.

w) Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.

x) Any charges related to the review of any diagnostic biopsy, material, or specimens submitted to a pathologist, or pathology lab, for histological review.

y) Charges for treatment rendered; (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any Member; or (b) by an employee of any Member.

z) Charges for treatment performed outside the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside the United States is limited to $100 (US dollars) per year.

aa) Dental services required while serving in the armed forces, or the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared.

frequently asked questions

Q. *What are CompBenefits Advantage dental plans?*

A. CompBenefits' Advantage plans are network-based dental plans that emphasize prevention and cost containment. In order to receive services, you simply select any participating general dentist in CompBenefits' Advantage network and make your appointment. You do not need to notify us of your choice. Advantage does not cover services (except emergency care) received from an out-of-network dentist.

Q. *How do the plans work?*

A. With CompBenefits' Advantage plans, you do not have to pre-select a primary dentist. When you want dental services, simply select any general dentist from the CompBenefits' Advantage network. Many preventive services are covered 100 percent after a co-payment for other listed procedures. Once you have paid your co-payment, you do not have to file any claim forms. For dental services that are not listed on your schedule of benefits, dentists will give you a 20 percent discount off their usual fees. You will pay your dentist directly, if applicable.

Q. *How many times a year can I visit my dentist?*

A. You are encouraged to visit your dentist regularly. With your CompBenefits' Advantage Plan, you are not limited to a specific number of visits per year.

Q. *How do I make appointments?*

A. Making an appointment is easy. Simply call a participating dental office on or after the date you receive your certificate of coverage, and you may schedule an appointment. You do not have to notify us when you have selected your Advantage dentist.

Q. *Do I need to select a participating dentist?*

A. Yes, you will choose an Advantage network dentist, but you are welcome to change to another participating dentist at any time without notifying us.

Q. *Is there any maximum coverage limitation?*

A. No, there are no maximum coverage limitations.

Q. *How do I pay for services?*

A. You will be responsible for a co-payment, based on your schedule of benefits.

Q. *What if I need a specialty dentist?*

A. When treatment by a participating specialty dentist is required, you will pay a co-payment for procedures listed on your schedule of benefits. For any other treatment, participating specialty dentists will give you a 20 percent discount off their usual fees.

Q. *Can I go online to find out more about my plan or get assistance?*

A. Yes. After you enroll, you can visit www.mycompbenefits.com to learn about your plan, to check your benefits, to use our Provider Locator, to send us an e-mail and more.

Humana Dental Members

How to Find a Dentist

If You Have Enrolled in the DHMO, you **MUST SELECT** Your Primary Care Dentist

How to Search for a Dentist

- Visit www.humanadental.com
- Click on Find a Doctor and select Search type Dental/Just Looking
- Select the DHMO radio button and enter your zip code
- Select CS150 DHMO / Prepaid Network Or
- Select HumanaDentalAdvantagePlus if you are on the Advantage plan
- Set your search Criteria
- Search for a General Dentistry or Specialist
- Select a dentist and locate the Dentist ID number
- Select the Show Info radio button to verify that the provider is accepting new patients.

After You Have Enrolled in the DHMO, you can Contact Humana Directly to Change Your Primary Care Dentist

Contact customer support center at

1-800-979-4760

Hours of Operation: Monday thru Friday 8 a.m.- 6 p.m. EST

Effective Date of Your Change –

Any changes done prior to the 15th of the month will be effective on the first day of the next month. (i.e. a change on July 12 will be effective August 1)

Any changes made after the 15th of the month will become effective for the first day of the second following month. (i.e. a change on July 16 will be effective September 1)

Humana

Humana®

Benefits Enrollment Form

Group Name: City of Lakeland

Please complete the following information:					
Social Security No.	Last Name		First	Middle	Date of Birth
Home Address			Home Phone		Gender
City	State	ZIP Code	Business Phone		Facility Number

List All Your Eligible Dependents That Are To Be Covered					
First MI Last			Facility Number	Sex	Birth Date
Spouse:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /
Child:				M ☐ F ☐	/ /

Effective Date	Plan Code	Group Number	Your E-mail Address	Agent Code
				1202039FL

PLEASE CHECK YOUR CHOICE	☐ Choice One DHMO Plan Group# 70073	☐ Choice Two EP602 w/ortho MID Plan Group# 80073	☐ Choice Three EP620 w/ortho Group# 80074	☐ Choice Four AVN+1S Group#
Monthly Rates				
Employee Only	☐ $12.28	☐ $24.32	☐ $31.00	☐ $18.70
Employee + One	☐ $23.16	☐ $42.88	☐ $54.64	☐ $36.48
Employee + Family	☐ $31.34	☐ $66.84	☐ $85.10	☐ $62.08

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: **X** _____ Date: _____