

About your plan

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

The Humana Family Dental PPO plan is designed for people who are looking to maintain their oral health through regular dental exams and cleanings. Members can maximize benefits by choosing one of the more than 117,000 dentists and specialists* in our nationwide network. There's no age requirement and you'll never be turned away for pre-existing conditions. Your plan starts your first month of eligibility so you know you're getting the best value for your money. Visit [Humana.com/Find-Care](https://www.humana.com/Find-Care) to find a participating dentist.

Who can enroll in this plan – Any individual or family can apply for this plan. There are only three requirements: must live in the U.S., must be a U.S. citizen or national (or lawfully present), and cannot be currently incarcerated. (<https://healthcare.gov/quick-guide/eligibility/>)

Date the plan starts: Your start date will be the first of the month following the day you enrolled.

The Humana Family Dental PPO plan is a Qualified Dental Health Plan insured by Humana Insurance Company, an issuer in the Health Insurance Marketplace.

How your plan works

Annual deductible

This is the dollar amount you pay for covered services each calendar year before the plan pays

Adult

\$50

Child

\$75

Family

Adult: \$100
Child: \$150
(Limited to 2 times the individual deductible)

Annual maximum

This is the maximum amount that the plan will pay during the calendar year for covered services

\$1,500

No annual maximum

\$1,500 per individual adult

Maximum out-of-pocket

Out of pocket maximum per calendar year for a policy with one covered child is \$350. The out-of-pocket maximum per calendar year for a policy with two or more covered children is \$350 per individual child or \$700 combined for all children.

Dental care services

Class I - Diagnostic and Preventive

- Routine oral examinations (limit once every 6 months)
- Periodontal examinations (limit once every 6 months)
- Bitewing X-rays (limit once per service date for single image; limit one set per 6 month per provider for 2 to 4 images; excludes full mouth and panoramic)
- Cleanings (limit once every 6 months)
- Topical fluoride treatment (limit three per 12-month period, topical fluoride varnish)
- Sealants (limit one per tooth every 36 months, age 19 and younger)

In-network coverage

Adult -
100% no deductible
No waiting period

Children -
100% no deductible
No waiting period

Out-of-network coverage[†]

Adult -
90% no deductible
No waiting period

Children -
90% no deductible
No waiting period

Dental care services (continued)

	In-network coverage	Out-of-network coverage [†]
Class II - General, Restorative, and Surgical <ul style="list-style-type: none"> Minor restorative services Fillings (limit once per 12-month period per permanent tooth; composite covered on front teeth only²) Palliative treatment of dental pain – per visit 	Adult - 80% after deductible No waiting period Children - 80% after deductible No waiting period	Adult - 70% after deductible No waiting period Children - 70% after deductible No waiting period
Class III - Major Restorative, Endodontic, Periodontic, and Prosthodontic Services <ul style="list-style-type: none"> Onlays (limit one per permanent tooth per five years, adult only, age 20 and older) Crowns (limit one per permanent tooth per five years, age 13 and older) Endodontics (root canals) Extractions Excision of benign lesion (child only, age 19 and younger) Root extraction Bridgework (limit once per five years, age 13 and older) Dentures including repair and adjustments Periodontics such as periodontic cleanings and gum therapies (age 13 and older) Simple and complex oral surgery 	Adult - 50% after deductible 6 month waiting period ^{††} Children - 50% after deductible No waiting period	Adult - 50% after deductible 6 month waiting period ^{††} Children - 50% after deductible No waiting period
Class IV - Medically Necessary³ <ul style="list-style-type: none"> Orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palate with or without cleft lip 	Adult - Not covered Children - 50% after deductible No waiting period	Adult - Not covered Children - 50% after deductible No waiting period

* Based on Humana network data, last accessed October 2023.

† Out-of-network dentists can bill you for charge above the amount covered by your Humana Family Dental PPO plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network. You can find dentists in the network by visiting [Humana.com/Find-Care](https://www.humana.com/Find-Care). Waiting periods and other limitations may apply; please see your policy for coverage details.

†† Policyholders who provide proof of prior comparable dental coverage may be exempt from waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount dental plans are not considered prior coverage.

An individual covered family member will receive benefits for covered services once they have met their individual deductible. The rest of the covered family members will receive benefits for covered services once they have met their individual deductible. The annual maximum benefit for each adult covered family member is shown above. Children age 19 and younger covered on the policy do not have an annual maximum.

Footnotes

1. "Gum Diseases and Other Diseases," American Academy of Periodontology, last accessed Oct. 12, 2023, <https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/>
2. Composite (white) fillings are only covered on anterior (front) teeth. An alternate benefit is allowed for composite fillings on posterior (back) teeth where the plan will cover the cost of an amalgam (silver) filling and the member is responsible for any cost over the covered amount.
3. Class IV Medically Necessary are covered benefits for children age 19 and younger.

Limitations and exclusions

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

1. Any expenses incurred and paid or reimbursed by worker's compensation or occupational disease act or law.
2. Services:
 - a. That are free or that a covered person would not be required to pay for if they did not have this insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. 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:
 - a. War or any act of war, whether declared or not;
 - b. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. Any service we consider cosmetic dentistry unless it is required as a result of an accidental injury sustained while the covered person is covered under the policy. We consider the following cosmetic dentistry procedures:
 - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
 - b. Any service performed primarily to improve appearance; or
 - c. Characterizations and personalization of prosthetic devices.
7. Charges for:
 - a. Precision or semi-precision attachments;
 - b. Overdentures and any endodontic treatment associated with overdentures; or
 - c. Other customized attachments.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in "Adult Dental Benefit" and "Pediatric/Child Dental Benefit" section, as applicable.
14. Services which are not dentally appropriate, or those which do not meet generally accepted standards of care within the dental provider community for treating the particular dental condition, or is experimental or investigational in nature.
15. Orthodontic services unless otherwise stated in this policy. Mail order self-administered orthodontics, not under the direction of a provider, are not covered.
16. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under the policy terminates.
17. Services provided by someone who ordinarily lives in the covered person's home or who is a family member.

Limitations and exclusions (continued)

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18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide/analgesia, bases, pulp caps, pulp testing, temporary dental services, study models/diagnostic casts, treatment plans, tissue preparation associated with the impression or placement of a restoration when charged as a separate service and desensitizing medicaments. These services are considered an integral part of the entire dental service.
21. Repair or replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull unless otherwise stated in the policy; or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to headaches.
23. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
24. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
25. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
26. Partial ostectomy/sequestrectomy for removal of non-vital bone.
27. The following services are considered as integral to the dental service. A separate fee for these services is not considered a covered expense.
 - a. Local anesthetics;
 - b. Bases;
 - c. Pulp caps;
 - d. Pulp tests;
 - e. Study models/diagnostic casts;
 - f. Tissue preparation associated with impression or placement of a restoration;
 - g. Treatment plans;
 - h. Nitrous oxide/analgesia;
 - i. Irrigation; and
 - j. Desensitizing medicaments.
28. Benefits for periodontal evaluations allowed only for covered persons showing signs or symptoms of periodontal disease and for covered persons with risk factors such as smoking, diabetes or related health issues. No benefit is payable when performed with a cleaning (prophylaxis).
29. Benefits for restorative services are limited as follows:
 - a. Fillings. Multiple restorations on the same tooth that have an overlapping surface are considered one restoration. Composite restorations are allowed on anterior teeth only. Alternate benefit of amalgam for composite allowed on pre-molar and molar teeth. The covered person will be responsible for the cost difference between the amalgam and composite filling for composite restorations on posterior teeth; and
 - b. Non-cast pre-fabricated stainless steel and esthetic stainless steel and resin crowns are limited to primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate service and will be payable as a comparable non-cast pre-fabricated stainless steel crown. The covered person will be responsible for the remaining expense incurred.
30. General anesthesia or conscious sedation must be administered by a provider in conjunction with a covered oral surgical, selected endodontic or periodontal surgical procedure. It may also be a covered service if the covered person has a documented physical, mental, or medically compromising condition. General anesthesia/conscious sedation will not be covered for the following reasons:
 - pain control, unless local anesthetic is ineffective or allergy to local anesthetic;
 - anxiety/fear

Limitations and exclusions (continued)

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

31. Initial placement of laboratory-fabricated restorations are only covered when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement of filling material. We will not cover the expense incurred for pin retention when done in conjunction with core build-up.
32. Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration may be replaced only if:
 - a. It has been at least five years since the prior insertion and is not, and cannot be made serviceable;
 - b. It is damaged beyond repair as a result of an accidental injury (non-chewing injury) while in the oral cavity; or
 - c. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis necessitates the replacement of the prosthesis.
33. For endodontic services, any test, X-ray, exam, laboratory or any other follow-up care is considered integral to root canal therapy and a separate fee for these services is not considered a covered expense.
34. If a root canal is performed within 30 days of a pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
35. Orthodontic services except for a child as shown in the "Pediatric/Child Dental Benefit" section. Repair and replacement of orthodontic appliances are not covered. Additionally, mail-order self-administered orthodontics, not under the direction of a provider, are not covered.
36. Services for congenital or developmental malformations, including but not limited to cleft palate (with or without cleft lip), upper and lower jaw malformations, enamel hypoplasia, fluorosis, and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
37. Any type of implant and all related services, including crowns or the prosthetic device attached to it including the removal of implants, except for a child as shown in the "Pediatric/Child Dental Benefit" section. No benefit will be allowed if it is determined that a standard prosthesis or restoration will satisfy the dental need.

Insured by Humana Insurance Company.

Policy number: CA HUMD IND 2025

Applications are subject to approval. Dental plans may have a minimum one-year initial contract period. 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.