

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 143,000 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/FindCare to find a participating dentist.

Who can enroll in this plan – Any individual or family can apply for this plan. To be eligible you must be a California resident, must be a U.S. citizen or national or lawfully present non-citizen, and cannot be 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

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

In-network coverage

Out-of-network coverage†

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)
- Routine cleanings (limit once every 6 months)
- Topical fluoride treatment (limit three per 12-month period, topical fluoride varnish)
- Sealants (limited to the first, second, and third permanent molars, once per tooth every 36 months, up to age 19)

Adult -

100% no deductible
No waiting period

Children -

100% no deductible
No waiting period

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 - Minor restorative services - Fillings (limit once per 12-month period per permanent tooth) - 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 - Onlays (limit one per permanent tooth per five years, adult only, age 19 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, up to age 19) - 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 Necessary² 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 November 2025.

† Out-of-network dental providers have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more than what the plan pays. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing. Benefits received are subject to any benefit maximums, limitations and/or exclusions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, the member may have to pay upfront and submit a request for reimbursement. Waiting periods and other limitations may apply; please see your policy for coverage details.

‡ Waiting period may be waived for policyholders who provide proof of 12 months prior coverage, with a lapse in coverage no more than 63 days. Prior coverage is defined as a stand-alone dental insurance plan that covered preventive and basic services. Discount plans and Medicaid plans are not considered creditable 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 up to age 19 covered on the policy do not have an annual maximum.

Footnotes

1. "Gum Diseases and Other Diseases," American Academy of Periodontology, last accessed Oct. 6, 2025, <https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/>
2. Class IV Medically Necessary are covered benefits for children up to age 19.

Limitations and exclusions

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

1. Any expenses incurred and paid or reimbursed by worker's compensation or occupational disease act or law, whether or not the covered person applied for coverage.
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.
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. Custom fabricated abutment, including placement.
8. Any service related to:
 - a. Altering vertical dimension of teeth or changing the spacing and/or shape of the 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. Any service for 3D imaging (cone beam images).
11. 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.
12. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
13. Prescription drugs or pre-medications, whether dispensed or prescribed.
14. Any service not specifically listed in "Adult Dental Benefit" or "Pediatric/Child Dental Benefit" section, as applicable.
15. 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.
16. Orthodontic services unless otherwise stated in the "Pediatric/Child Dental Benefit" section. Mail order self-administered orthodontics, not under the direction of a provider, are not covered.
17. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under the policy terminates.
18. Services provided by someone who ordinarily lives in the covered person's home or who is a family member.

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 policy for a complete list of limitations and exclusions. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

19. Charges exceeding the reimbursement limit for the service.
20. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
21. 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.
22. Repair or replacement of orthodontic appliances.
23. Any non-emergent dental expenses incurred for services rendered outside of the United States.
24. Any services for tooth transplantation.
25. Any separate fees for pre and post-operative services.
26. 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.
27. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
28. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
29. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
30. Partial ostectomy/sequestrectomy for removal of non-vital bone.
31. 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.
32. 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).
33. 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.

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 policy for a complete list of limitations and exclusions. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

34. 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
35. 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.
36. 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.
37. 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.
38. 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.
39. 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.
40. 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.
41. 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 2027

This plan has a minimum one-year initial contract period.

Applications are subject to approval. 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.

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc. provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us as well as provides free language assistance services to people whose primary language is not English, including qualified sign language interpreters and written information in other formats.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

California members or residents: You may also call the 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). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Kreyòl Ayisyen (Haitian Creole): Rele nimewo ki endike anwo a pou resevwa sèvis èd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian): Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید..

हिंदी (Hindi): भाषा सेवाएं मुफ्त में प्राप्त करने के लिए, ऊपर दिए गए नंबर पर कॉल करें।

Հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong): Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.