Smart Choice - 2027
Individual Dental

Idaho High Plan

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 Smart Choice dental 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 an Idaho 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 Smart Choice dental plan is a Qualified Dental Health Plan insured by Humana Insurance Company, an issuer in the Health Insurance Marketplace.

How your plan works

	Adult	Family	Pediatric
Annual deductible This is the dollar amount you pay for covered services each calendar year before the plan pays	$50	$50 per adult $50 per child	$50
Annual maximum This is the maximum amount that the plan will pay during the calendar year for covered services	$1,000	$1,000 per individual adult	No annual maximum
Maximum out-of-pocket	Out of pocket maximum per calendar year for a policy with one covered child is $450. The out-of-pocket maximum per calendar year for a policy with two or more covered children is $450 per individual child or $900 combined for all children.		

Dental care services	In-network coverage	Out-of-network coverage†
Class I - Diagnostic and Preventive • Routine oral examinations (limit two per calendar year) • Periodontal examinations (limit two per calendar year) • Bitewing X-rays (limit two sets per calendar year, excludes full mouth and panoramic) • Routine cleanings (limit two per calendar year) • Topical fluoride treatment (limit two per calendar year, age 19 and younger) • Sealants (limit one per tooth every 36 months, age 19 and younger)	Adult - 100% no deductible No waiting period Children - 100% no deductible No waiting period	Adult - 80% after deductible No waiting period Children - 100% no deductible No waiting period

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Dental care services (continued)

	In-network coverage	Out-of-network coverage†
Class II - General, Restorative, and Surgical • Minor restorative services • Fillings (composite covered on front teeth only[2]) • Simple and complex oral surgery • Extractions • Excision of benign lesion (adult only, age 20 and older) • Palliative treatment of dental pain – per visit	Adult - 70% after deductible 6 month waiting period Children - 80% after deductible No waiting period	Adult - 50% after deductible 6 month waiting period Children - 80% after deductible No waiting period
Class III - Major Restorative, Endodontic, Periodontic, and Prosthodontic Services • Resin onlays, inlays and crowns (limit one per permanent tooth every five years) • Crowns • Endodontics (root canals) • Root extraction	Adult - 40% after deductible 12 month waiting period Children - 50% after deductible No waiting period	Adult - 20% after deductible 12 month waiting period Children - 50% after deductible No waiting period
• Bridgework (child only, age 19 and younger) • Dentures including repair, and adjustments (child only, age 19 and younger) • Periodontics such as periodontic cleanings and gum therapies (child only, age 19 and younger)	Adult - Not covered Children - 50% after deductible No waiting period	Adult - Not covered Children - 50% after deductible No waiting period
Class IV - Medically Necessary[3] • 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.

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. 6, 2025, 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 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 while a covered person qualifies for any Workers' 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. Taking part in a riot or insurrections;
    c. Participation in a felony;
    d. Engaging in an illegal profession or occupation;
    e. Any act of armed conflict; or
    f. Service in the armed forces or units auxiliary to it.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child.
7. Charges for:
    a. Precision or semi-precision attachments;
    b. Any services for 3D imaging (cone beam images);
    c. Additional charges related to materials or equipment used in the delivery of dental care;
    d. Overdentures and any endodontic treatment associated with overdentures; or
    e. Other customized attachments.
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. 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” or “Pediatric Dental Benefit” section, as applicable.
14. Any service that we determine:
    a. Is not an eligible benefit based on clinical review;
    b. Does not offer a favorable prognosis;
    c. Does not have uniform professional endorsement; or
    d. Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless otherwise stated in the "Pediatric Dental Benefit" section. 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.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.

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:

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 non-emergent dental expenses incurred for services rendered outside of the United States.
23. Any services for tooth transplantation.
24. Any separate fees for pre and post-operative services.
25. 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.
26. Elective removal of non-pathologic impacted teeth.
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.

Insured by Humana Insurance Company.

Policy number: ID HUMD IND 2027 H

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.