Bright Plus

Individual Dental

Minnesota

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 Bright Plus dental plan is designed for people who are looking to maintain their oral health through regular dental exams and cleanings. The plan offers coverage for preventive and basic services like routine cleanings and exams, fillings, extractions, a $100 teeth whitening allowance and special discounts. Members can maximize benefits by choosing one of the more than 143,000 dentists and specialists* in our nationwide network. Visit **Humana.com/FindCare** to find a participating dentist.

Who can enroll in this plan – Anyone can enroll in this plan.

How your plan works

	Individual	Family
Calendar year deductible This is the dollar amount you pay for covered services each calendar year before the plan pays	$50 (deductible waived for in-network preventive services)	$150 (deductible waived for in-network preventive services)
Annual maximum This is the maximum amount that the plan will pay in a calendar year for covered services	$1,250 per individual on the plan	

Dental care services	In-network coverage	Out-of-network coverage†
Preventive services (no waiting period) • Routine oral examinations (limit two every calendar year) • Limited oral evaluation (limit two every calendar year) • Comprehensive oral evaluation (limit two every calendar year) • Bitewing X-rays (limit one set, up to four films, every calendar year) • Panoramic film combined with full mouth (limit one every five years) • Routine cleanings (limit two every calendar year) • Topical fluoride treatment (limit one every calendar year, age 14 and younger) • Sealants (limit of one per tooth per lifetime, age 14 and younger)	100% no deductible	70% after deductible

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Dental care services (continued)	In-network coverage	Out-of-network coverage†
Basic services (90 day waiting period) • Extractions and root removal • Fillings (limit two every calendar year, composite covered on front teeth only[2]) • Space maintainers (age 14 and younger, initial placement only, not covered on permanent teeth) • Prefabricated stainless steel crowns • Palliative treatment of dental pain – per visit	60% after deductible	30% after deductible

This policy has a $100 teeth whitening allowance available once per calendar year. Benefits are available for expenses incurred for teeth whitening services and supplies when performed in the office by a dentist. An allowance is the maximum amount we will pay for a covered service. Deductible and waiting periods do not apply to the teeth whitening allowance.

* 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.

Important to know: If further clarification regarding coverage and benefits is needed, please ask your dentist for a pretreatment estimate.

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.

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 claims that have been paid for any Workers' 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 United States government-owned or operated hospital/institution/agency.
3. For covered persons who are serving in the armed forces, and 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 any authority.
4. Failure to keep an appointment with the provider.
5. Services we consider cosmetic dentistry unless it is required as a result of an accidental injury sustained while the covered person is covered under this policy.
6. Except when necessary for the treatment of temporomandibular and/or craniomandibular disorders, any service related to:
    a. Any type of implant and all related services, including crowns or the prosthetic device attached to it;
    b. Precision or semi-precision attachments;
    c. Overdentures and any endodontic treatment associated with overdentures;
    d. Other customized attachments;
    e. 3D imaging;
    f. Temporary and interim dental services;
    g. Separate charges for materials or use of equipment, such as lasers; or
    h. Separate charges for treatment rendered in a clinic, dental or medical facility owned, operated, sponsored or maintained by either (i) the employer or any covered person; or (ii) by an employee of any covered person.
7. 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.
8. Infection control, including but not limited to sterilization techniques.
9. 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.
10. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
11. Prescription drugs or pre-medications, whether dispensed or prescribed.

Limitations and exclusions (continued)

12. Services that we determine:
    a. Are not eligible for benefits based upon clinical review;
    b. Do not offer a favorable prognosis;
    c. Do not have uniform professional acceptance; or
    d. Are deemed to be experimental or investigational in nature.
13. Orthodontic services.
14. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in the covered person's home or is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
18. Repair or replacement of orthodontic appliances.
19. Elective removal of non-pathologic impacted teeth.
20. Service for orthognathic surgery.
21. Services generally considered medical or covered by a medical plan.
22. Services for destruction of lesions by any method.
23. Services for tooth transplantation.
24. Services for removal of a foreign body from the oral tissue or bone.
25. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
26. Any separate fees for pre and post-operative care.
27. Replacement of restorations (fillings) placed less than two years ago.
28. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Insured by Humana Insurance Company.

Policy number: MN-71145 1/2025

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. Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.