Bright Plus

Individual Dental

New Hampshire

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 135,000 dentists and specialists* in our nationwide network. Visit **Humana.com/Find-Care** 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) • 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

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 October 2024.

† Out-of-network dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network. Waiting periods and other limitations may apply; please see your policy for coverage details.

Important to know: Dental plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. 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. 11, 2024, 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 expenses incurred while a covered person qualifies for any 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 Medicaid); or
    c. Treatment provided in a government hospital.
3. Any loss caused or contributed by:
    a. War or any act of war, whether declared or not;
    b. Taking part in a riot;
    c. Any act of armed conflict; or
    d. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. 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.
7. Charges for:
    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.
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. Services not specifically listed in the "Schedule of Policy Benefits" section.
14. Services shown as "Not Covered" in the "Schedule of Policy Benefits" section.

Limitations and exclusions (continued)

15. 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.
16. Orthodontic services.
17. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this policy terminates.
18. Services provided by someone who ordinarily lives in the covered person's home or is a family member.
19. Charges exceeding the reimbursement limit for the service.
20. 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.
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 or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Service for orthognathic surgery.
25. Services generally considered medical or covered by a medical plan.
26. Services for destruction of lesions by any method.
27. Services for tooth transplantation.
28. Services for removal of a foreign body from the oral tissue or bone.
29. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
30. Any separate fees for pre and post-operative care.
31. Replacement of restorations (fillings) placed less than two years ago.
32. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Insured by HumanaDental Insurance Company.

Policy number: NH-71163-BP

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.

Enclosure: Dental Policy Outline of Coverage

HumanaDental Insurance Company
1100 Employers Blvd.
Green Bay, WI 54344

INDIVIDUAL DENTAL POLICY – NH-71163-HD
OUTLINE OF COVERAGE
THIS POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

READ YOUR POLICY CAREFULLY! This outline of coverage provides a very brief description of the important features coverage. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This Dental coverage is designed to provide, to persons insured, benefits for covered dental expenses, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the specific Dental benefits described and any additional benefit described below:

Please read this policy to fully understand all terms, conditions, limitations and exclusions that apply.

Benefit period: Calendar year

Dental Deductible

Individual deductible:
$50 per year per covered person when services are provided by a network or non-network provider.

Aggregate Family deductible:
$150 per year when services are provided by a network or non-network provider.

Annual Maximum: $1250

Preventive Services:
Network provider: Benefits are paid at 100%.
Non-network provider: Benefits are paid at 70% after the deductible has been met.

Basic Services:
Network provider: Benefits are paid at 60% after the deductible has been met.
Non-network provider: Benefits are paid at 30% after the deductible has been met.

We pay benefits for covered services as explained in this section.

Teeth Whitening Services

This policy has a $100 teeth whitening annual allowance. 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.

Preventive Services
There is no waiting period for all services in this category.

1. Exams - Limited to a combined maximum of two per year:
   a. Periodic oral evaluations.
   b. Comprehensive oral evaluations.
   c. Limited and problem focused oral evaluations.
   d. Oral evaluations for a patient under three years of age and counseling with primary caregiver.
   e. Detailed and extensive oral evaluation-problem focused, by report.
   f. Re-evaluations – limited problem focused.
2. Periodontal evaluations. Benefit 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). One every three years.
3. Cleaning (prophylaxis), including all scaling and polishing procedures, two per year.
4. Topical fluoride treatment – one per year, limited to 14 years and younger.
5. Bitewing X-rays – One set up to four films per year.
6. Intra-oral comprehensive series X-rays (usually 14-22 films, including bitewings), or panoramic film X-rays – once every five years. If the total cost of periapical and bitewing x-rays exceeds the cost of a comprehensive series of x-rays, the plan will consider these as a comprehensive series.
7. Other X-rays including intra-oral periapical & occlusal X-rays, one per year.
8. Sealants – application provided to covered persons age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations - one per tooth per lifetime.

Basic Services
There is a 3 month waiting period for all services in this category.

1. Fillings (restorations) – two per year. Multiple restorations on the same tooth that have an overlapping surface are considered one restoration. Composite restorations 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.
2. Non-cast pre-fabricated stainless steel and esthetic stainless steel and resin crowns on teeth that cannot be adequately restored with amalgam or composite restorations.
3. Palliative treatment. Usually performed for, but not limited to, the following acute conditions:
   a. Toothache;
   b. Localized infection;
   c. Muscular pain; or
   d. Sensitivity and irritations of the soft tissue.
   We will consider the service as a separate benefit only if no other service, except X-rays and/or exam, is provided during the same visit.
4. The following oral surgery services:
   a. Extraction – coronal remnants of a primary tooth.
   b. Extraction – erupted tooth or exposed root.
   c. Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth.
5. Space maintainers for retaining space when a primary tooth is prematurely lost. Services are payable only for dependents age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.

6. Recementation of space maintainer, when performed by a dentist or practice that did not place the appliance.
7. Deep sedation and intravenous moderate (conscious) sedation/analgesia.

Major Services
Not covered

Orthodontic Services
Not covered

PPO

You and your covered dependents have the freedom to choose the provider of choice. However, maximum benefits will be received by seeing a network provider. A non-network provider may balance bill you for any expense incurred that exceeds our reimbursement limit.

If you or a covered person are traveling or need emergency care and are unable to access care from a network provider, benefits will be paid at the non-network level.

Limitations & exclusions

In addition to any limitations and exclusions listed in "Schedule of Policy Benefits" or "Definition" sections, the policy does not provide benefits for the following:

1. Any expenses incurred while a covered person qualifies for any 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 Medicaid); or
   c. Treatment provided in a government hospital.
3. Any loss caused or contributed by:
   a. War or any act of war, whether declared or not;
   b. Taking part in a riot;
   c. Any act of armed conflict; or
   d. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. Services 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.
7. Charges for:
   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.

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. Services not specifically listed in the "Schedule of Policy Benefits" section.
14. Services shown as "Not Covered" in the "Schedule of Policy Benefits" section.
15. 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.
16. Orthodontic services.
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 is a family member.
19. Charges exceeding the reimbursement limit for the service.
20. 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.
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 or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Service for orthognathic surgery.
25. Services generally considered medical or covered by a medical plan.
26. Services for destruction of lesions by any method.
27. Services for tooth transplantation.
28. Services for removal of a foreign body from the oral tissue or bone.
29. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
30. Any separate fees for pre and post-operative care.
31. Replacement of restorations (fillings) placed less than two years ago.
32. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Changes to your premium

Premium may change when:

1. Covered persons are added or deleted;
2. Coverage is increased or decreased;
3. A covered person moves to a different zip code or county;
4. Premium payment method is changed;
5. A new rate table applies;
6. Any covered person's age increases;
7. Any covered person's rating classification changes; or
8. A misstatement on the application form results in the proper amount due not being charged.

We will provide you 30 days advance notice of any premium change. Your continued payment of premium will stand as proof of your agreement to the change.

Terminating coverage

Your insurance coverage may end at any time, as stated below. Coverage terminates on the earliest of the following events:

1. Termination date of the policy;
2. Failure to pay premium by the required due date, subject to grace period;
3. The date a covered person commits fraud or intentional material misrepresentation of a material fact, as determined by us;
4. The end of the month you are no longer eligible for coverage;
5. For a dependent, the end of the month your insurance terminates;
6. For a dependent, the end of the month he or she no longer meets the definition of a dependent;
7. The receipt of *your* request or specified date that insurance be terminated for *you* and/or *your dependents*;
8. The end of the month that a change in your legal residence from the state in which the policy was issued occurs; or
9. The end of the month you cease to live in the service area or area in which we are authorized to do business, as determined by us. Call the telephone number on your ID card for the policy's service area.

We may also terminate your coverage with advance notice when:

1. We have a right or defense to take such action by law; or
2. We cease to offer a type of policy or cease to do business in the individual dental insurance market, as allowed by state or federal law.

Your duty to notify us

You are responsible to notify us of any of the events stated above which would result in the termination of the policy or the termination of a covered person.

If we accept premium for any covered person extending beyond the date, age or event specified in this provision as a reason for termination, then coverage for the covered person will continue during the period for which an identifiable premium was accepted, except where such acceptance of premium was based on misstatement of age.