Complete Dental

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 Complete 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, basic and major services like routine cleanings and exams, fillings, dentures and extractions. 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 year one, $1,500 year two and after, 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 one every calendar year) • Comprehensive oral evaluation (limit one every three years) • Bitewing X-rays (limit one set of films every calendar year for covered persons age 10 and younger and up to four films every calendar year for covered persons age 11 and older) • Panoramic film combined with full mouth (limit one every five years, age 12 and older) • Cleanings (limit two every calendar year) • Topical fluoride treatment (limit two every calendar year) • Sealants (limit of once per tooth per lifetime, age 14 and younger for primary teeth only)	100% no deductible	100% after deductible
Basic services (6 month waiting period applies - policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period.[2]) • Simple extractions and root removal • Fillings (limit one per tooth every two years, composite covered on front teeth only[3]) • Space maintainers (age 14 and younger for primary teeth only) • Prefabricated stainless steel crowns • Palliative treatment of dental pain – per visit	80% after deductible	80% after deductible

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Dental care services (continued)	In-network coverage	Out-of-network coverage†
Major services (12 month waiting period applies - policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period.[2]) • Endodontics - Root canals (limit one per tooth per lifetime) • Complete dentures (limit one every five years) • Removable partial dentures (limit one every five years) • Denture repair and adjustments • Crowns (limit one per tooth every five years) • Onlays and inlays (limit one per tooth every five years) • Surgical extractions • Periodontal maintenance (limit two every calendar year) - *no waiting period for this service* • Periodontal scaling and root planing (limit one per quadrant every three years) - *no waiting period for this service* *Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.*	50% after deductible	50% after deductible

* 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. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount dental plans are not considered prior coverage.

3. 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 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 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. Commission of a criminal act;
    d. Engaging in an illegal profession or occupation;
    e. Any act of armed conflict; or
    f. 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.
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-71145-HD

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-71145-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:

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 combined in and out of network per covered person:
$1250 first year
$1500 second year and thereafter

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

Basic Services:
Network provider: Benefits are paid at 80% after the deductible has been met.
Non-network provider: Benefits are paid at 80% after the deductible has been met.

Major Services:
Network provider: Benefits are paid at 50% after the deductible has been met.
Non-network provider: Benefits are paid at 50% after the deductible has been met.

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

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

1. Periodic oral examination - two every year.
2. Limited problem focused oral evaluation, detailed and extensive problem focused evaluation by report or limited problem focused re-evaluation – one every year.
3. Comprehensive oral evaluation – one every three years.
4. Comprehensive periodontal evaluation – one every three years.
5. Cleaning (prophylaxis), including all scaling and polishing procedures. Two every year, combined with periodontal scaling in presence of generalized moderate or severe gingival inflammation.
6. Topical fluoride treatment – two every year.
7. 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.
8. Bitewing X-rays – one set per calendar year.
9. Other x-rays, including intra-oral periapical and occlusal and extra-oral x-rays. Limited to x-rays necessary to diagnose a specific treatment.
10. 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.

Basic Services
There is a 6 month waiting period for all services in this category.

1. Fillings (restorations) - one per tooth per surface every two years. 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. 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.
3. Non-cast stainless steel, resin or porcelain/ceramic pre-fabricated crown – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.
4. The following oral surgery services:
   a. Extractions – coronal remnants of a deciduous tooth.
   b. Extraction – erupted tooth or exposed root.
   c. General anesthesia based on clinical review of documentation provided, when administered by a provider in conjunction with a covered oral surgical service.
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. Recementing of inlays, onlays, and crowns.
7. Occlusal adjustment – one per mouth every three years, in conjunction with periodontal surgery.

Major Services
There is no waiting period for the following services in this category:

Periodontic services
1. Periodontal scaling and root planing, available at a maximum of once per quadrant every three years.
2. Periodontal scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. One every year, this limitation also reduces the limit for cleaning (prophylaxis) services.
3. Periodontal maintenance (following periodontal therapy) – two every year.

There is no a 12 month waiting period for the following services in this category:
Periodontic services
1. Periodontal surgery, available at a maximum of once per quadrant in a three-year period. If more than one surgical service is performed on the same day, we will consider only the most inclusive service performed as a covered service.

Endodontic services
1. Root canal therapy, including root canal treatments and root canal fillings for permanent teeth-once per tooth per lifetime. Any X-ray, test, laboratory, exam or follow-up care is considered integral to root canal therapy.
2. Root canal retreatment, including root canal treatments and root canal fillings for permanent teeth-once per tooth per lifetime.
3. Apicoectomy - procedure available for permanent teeth only.
4. Vital pulpotomy - procedure available for primary teeth only.

Prosthodontic and other major services
1. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. Covered services include inlays, onlays, crowns, veneers, core build-ups, and posts. These services are covered only on permanent teeth. Inlays are considered an alternate service and will be payable as a comparable amalgam filling. We will not cover the expense incurred for pin retention when done in conjunction with core build-up.
2. Initial placement of full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while you are covered under the policy. Covered services include retainer inlays, retainer onlays, and retainer crowns. Covered expense includes removable partial dentures and full dentures. Initial placement includes all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. We will not cover replacement of congenitally missing teeth.
3. Repairs of full or partial dentures. Repairs of full or partial dentures by report - limited to one every five years.
4. Denture adjustments – procedure available only for adjustments done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation.
5. Recementing fixed partial denture – one every five years.
6. Replacement of partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can 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.

These services are covered only on permanent teeth.

7. The following oral surgery services:
   a. Surgical extractions (we will not cover the elective removal of non-pathologic impacted teeth);
   b. Bone smoothing;
   c. Trim or remove over growth or non-vital tissue or bone; or
   d. Removal of tooth or root from sinus and closing opening between mouth and sinus.
8. Denture relines or rebases – one per arch in a three year period.

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. Commission of a criminal act;
   d. Engaging in an illegal profession or occupation;
   e. Any act of armed conflict; or
   f. 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 end of the month following your request that insurance be terminated for you and/or your dependents given that coverage has been continuously in force for at least 12 months from the effective date of the policy;
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.

If you fail to provide timely notification of these events, the termination date and premium refund (if any) will be determined by us.