Loyalty 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 Loyalty 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, basic and major services like routine cleanings and exams, fillings, dentures and extractions. 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

- **Loyalty benefits –** There is confidence in knowing your dental plan. The longer you are a member, the greater your benefits, such as:
  - Increased coverage for procedures such as fillings, root canals, and crowns.
  - Increased maximum amounts that the plan will pay annually.
  - One-time deductible for as long as you stay on the plan.
- **Choice –** The plan pays the same percentage no matter which dentist you visit. Save even more by choosing a dentist location in the Humana dental network. Visit **Humana.com/FindCare** to find a participating dentist.
- **Access to benefits –** With no waiting periods, you can get the dental work you need upon your effective date and your plan benefits will help cover the cost.
- **Helps maintain good oral health –** Most preventive services are covered at 100 percent.

One-time deductible This is the dollar amount you pay for covered services before the plan pays	**Individual** **Individual + One** **Family**	$150 $300 $450
Annual maximum This is the maximum amount that the plan will pay in a plan year for covered services	**First year** **Second year** **Subsequent years**	$1,000 per individual on the plan $1,250 per individual on the plan $1,500 per individual on the plan

Dental care services†	First year	Second year	Subsequent years
Preventive services (no waiting period) • Routine oral examinations (limit two every plan year) • Periodontal examinations (limit two every plan year) • Routine cleanings (limit two every plan year) • Topical fluoride treatment (limit two every plan year, age 14 and younger) • Sealants (limit one per tooth per lifetime, age 14 and younger)	100% no deductible	100% no deductible	100% no deductible

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Dental care services† (continued)	First year	Second year	Subsequent years
Basic services (no waiting period) • Simple extractions and root removal (limit two every plan year) • Fillings (limit two every plan year, composite covered on front teeth only[2]) • Miscellaneous X-rays (limit one every plan year) • Bitewing X-rays (limit one set of two or four every plan year) • Full mouth or panoramic X-rays (limit one every five years) • Palliative treatment of dental pain – per visit (limit two every plan year)	40% after deductible	55% after deductible	70% after deductible
Major services (no waiting period) • Root canals (limit one per tooth every two years, permanent teeth only) • Periodontal cleanings (limit two every plan year) • Complete dentures (limit one every five years) • Removable partial dentures (limit one every five years) • Denture repair and adjustments (limit one every plan year) • Crowns (limit one per tooth every five years) • Onlays (limit one per tooth every five years) • Space maintainers (age 14 and younger, initial placement only, not covered on permanent teeth) • Surgical extractions • Oral surgery *Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.*	20% after deductible	30% after deductible	50% after deductible
Orthodontia services • Adult and child orthodontia	Member may receive a discount on these non-covered services. You may contact your participating provider to determine if any discounts are available on non-covered services.		

* 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.

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Important to know: If further clarification regarding coverage and benefits is needed, please ask your dentist for a pretreatment estimate. Payment may include an administration fee. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment.

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. In addition to any limitations and exclusions listed in "Schedule of Policy Benefits" or "Definition" sections, this 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 illegal profession or occupation;
    e. Any act of armed conflict; or
    f. Any conflict involving armed forces of any authority.
4. 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.
5. 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.
6. 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.
7. Infection control, including but not limited to sterilization techniques.
8. 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.
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
10. Prescription drugs or pre-medications, whether dispensed or prescribed.
11. Any service not specifically listed in the "Schedule of Policy Benefits" section.
12. Any service shown as "Not Covered" in the "Schedule of Policy Benefits" section.

Limitations and exclusions (continued)

13. 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.
14. Orthodontic services.
15. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this policy terminates.
16. Services provided by someone who ordinarily lives in the covered person's home or is a family member.
17. Charges exceeding the reimbursement limit for the service.
18. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments 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.
19. Repair or replacement of orthodontic appliances.
20. 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.
21. Elective removal of non-pathologic impacted teeth.
22. Service for orthognathic surgery.
23. Services generally considered medical or covered by a medical plan.
24. Any services for destruction of lesions by any method.
25. Any services for tooth transplantation.
26. Any services for removal of a foreign body from the oral tissue or bone.
27. Any services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
28. Any separate fees for pre and post-operative care.
29. Replacement of restorations (fillings) placed less than two years ago.
30. 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 LOY

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

Humana.

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

DENTAL POLICY
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 brief description of some important features of the coverage. This is not the insurance policy 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:

BENEFITS: The individual dental policy is designed to provide coverage for covered expenses, subject to all conditions, limitations, exclusions and maximums set forth in the policy.

Lifetime Individual deductible:
$150

Aggregate Family deductible:
$450

Annual Maximum combined in and out of network per covered person:
$1000 first year
$1250 second year
$1500 third year and thereafter

Preventive Services:
First Plan Year: Benefits are paid at 100%.
Second Plan Year: Benefits are paid at 100%.
Third Plan Year: Benefits are paid at 100%.

Basic Services
First Plan Year: Benefits are paid at 40% after deductible.
Second Plan Year: Benefits are paid at 55% after deductible.
Third Plan Year: Benefits are paid at 70% after deductible.

Major Services:
First Plan Year: Benefits are paid at 20% after deductible.
Second Plan Year: Benefits are paid at 30% after deductible.
Third Plan Year: Benefits are paid at 50% after deductible.

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

Covered Preventive Services

1. Periodic, Comprehensive, Limited or problem focused oral evaluations - two every year.
2. Periodontal evaluations – two every year.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – two every year.
4. Topical fluoride treatment – provided to covered persons age 14 and younger-two every year.
5. 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.

Covered Basic Services

1. Fillings (restorations): Limited to 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. Palliative Treatment. Limited to two per year. Services include palliative procedures for treatment to the teeth and supporting structures. 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. Oral surgery services, limited to two per year, including:
   a. Extractions – coronal remnants of a deciduous tooth.
   b. Extraction – erupted tooth or exposed root.
4. Bitewing X-rays – one set of up to four films every year.
5. Miscellaneous X-rays - only to diagnose specific treatment – one every year.
6. Intra-oral complete series X-rays (at least 14 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 complete series of x-rays, the plan will consider these as a complete series.

Covered Major Services

Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only, once per tooth in a two year period. Any X-ray, test, laboratory, exam or follow-up care is considered integral to root canal therapy.
2. Apicoectomy - procedure available for permanent teeth only.
3. Vital pulpotomy – procedure available for deciduous (baby) teeth only.
4. Pulp tests - allowed only with emergency exam.

Periodontic services

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three year period.
2. 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.
3. Occlusal Guards.
4. Periodontal maintenance (following periodontal therapy) – procedure available twice per year.
5. Separate fees for pre and post operative care and re-evaluation within three months are not covered.

Prosthodontic and other major services

1. Non-cast stainless steel pre-fabricated crowns – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.
2. Repairs of full or partial dentures. Limited to one per year.

3. 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.
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. Limited to one per year.
5. 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 onlays, crowns, veneers, core build-ups and posts. These services are covered only on permanent teeth. One per tooth per five years.
6. 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 this plan. Covered expense includes removable partial dentures and full dentures. Services include 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. One per five years.
7. 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.

8. Oral surgery services.
    a. Surgical Extractions (We will not cover the elective removal of non-pathologic impacted teeth);
    b. Bone Smoothing;
    c. General anesthesia when medically necessary and administered by a dentist in conjunction with a covered oral surgical procedure.
9. Denture relines or rebases – once in a three year period, not covered within six months of installation.
10. Tissue conditioning, one per 5 years, not covered within six months of installation.

The following services are considered as integral to the dental service. A separate fee for these services is not considered a covered expense.

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Temporary dental services;
5. Study models/diagnostic casts;
6. Tissue preparation associated with impression or placement of a restoration;
7. Treatment plans;
8. Occlusal (chewing or grinding surfaces of molar and bicuspid teeth) adjustments;
9. Nitrous oxide;
10. Irrigation; and
11. Removal of restorations, prosthesis or appliances.

LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL CATEGORIES:

In addition to the limitations and exclusions listed in the service categories, no benefits are payable for:

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.

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.