Bright Plus

Individual Dental

New York

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	50% 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. Cosmetic Services

   We do not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be necessary.
2. Experimental or Investigational Treatment

   We do not cover any health care service, procedure, treatment, or device that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under this policy for non-investigational treatments. See the General Provisions, Appeal Rights section of this policy for a further explanation of your appeal rights.
3. Felony Participation

   We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.
4. Government Facility

   We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.
5. Medical Services

   We do not cover medical services or dental services that are medical in nature, including any hospital charges or prescription drug charges.
6. Medically Necessary

   In general, we will not cover any dental service, procedure, treatment, test or device that we determine is not medically necessary. If an external appeal agent certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise covered under the terms of this policy.
7. Medicare or Other Governmental Program

   We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).
8. Military Service

   We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
9. Services Not Listed

   We do not cover services that are not listed in this policy as being covered.
10. Services Provided by an Immediate Family Member

    We do not cover services performed by a member of the covered person's immediate family.
11. Services Separately Billed by Hospital Employees

    We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.
12. Services with No Charge

    We do not cover services for which no charge is normally made.
13. Temporomandibular Joint Dysfunction (TMJ)

    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.

Limitations and exclusions (continued)

14. War
    We do not cover an illness, treatment or medical condition due to war, declared or undeclared.
15. Workers' Compensation
    We do not cover services if benefits for such services are provided under any state or federal workers' compensation, employers' liability or occupational disease law.

Insured by Humana Insurance Company of New York.

Policy number: NY-71145

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.

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