Complete Dental

Individual Dental

Pennsylvania

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 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 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 elimination 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) • Routine 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

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Dental care services (continued)	In-network coverage	Out-of-network coverage†
Basic services (30 day elimination period‡ – may be waived with proof of prior coverage[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
Major services (12 month elimination period‡ – may be waived with proof of prior coverage[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 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.

‡ You may sometimes see elimination period referred to as waiting period.

Important to know: This plan has a minimum one-year initial contract period. If further clarification regarding coverage and benefits is needed, please ask your dentist for a pretreatment estimate.

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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. Elimination period may be waived for policyholders who provide proof of 12 months prior coverage, with a lapse in coverage no more than 63 days. Prior coverage is defined as a stand-alone dental insurance plan that covered preventive and basic services. Discount plans, Mandatory Supplemental Benefits included in a Medicare Advantage plan and Medicaid plans are not considered creditable 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 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 arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which coverage was available under 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. 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 loss to which a contributing cause was your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation.
    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 Humana Insurance Company.

Policy number: PA-71145 9/24

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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