Smart Choice - 2025

Individual Dental

Utah Basic Plan

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 Humana Smart Choice dental plan is designed for people who are looking to maintain their oral health through regular dental exams and cleanings. Members can maximize benefits by choosing one of the more than 117,000 dentists and specialists* in our nationwide network. There's no age requirement and you'll never be turned away for pre-existing conditions. Your plan starts your first month of eligibility so you know you're getting the best value for your money. Visit **Humana.com/Find-Care** to find a participating dentist.

Who can enroll in this plan – Any individual or family can apply for this plan. There are only three requirements: must live in the U.S., must be a U.S. citizen or national (or lawfully present), and cannot be currently incarcerated. (https://healthcare.gov/quick-guide/eligibility/)

Date the plan starts: Your start date will be the first of the month following the day you enrolled.

The Humana Smart Choice dental plan is a Qualified Dental Health Plan insured by Humana Insurance Company, an issuer in the Health Insurance Marketplace.

How your plan works

	Adult	Family	Pediatric
Annual deductible This is the dollar amount you pay for covered services each calendar year before the plan pays	$45	$45 per adult $45 per child	$45
Annual maximum This is the maximum amount that the plan will pay during the calendar year for covered services	$1,000	$1,000 per individual adult	No annual maximum
Maximum out-of-pocket	Out of pocket maximum per calendar year for a policy with one covered child is $425. The out-of-pocket maximum per calendar year for a policy with two or more covered children is $425 per individual child or $850 combined for all children.		

Dental care services	In-network coverage	Out-of-network coverage†
Class I - Diagnostic and Preventive • Routine oral examinations (limit two per calendar year) • Periodontal examinations (limit one every 36 months) • Bitewing X-rays (limit two sets per calendar year, excludes full mouth and panoramic) • Cleanings (limit two per calendar year) • Topical fluoride treatment (limit two per calendar year, age 19 and younger) (topical fluoride varnish ages 0-5, 100% no deductible when visiting an in-network provider) • Sealants (limit one per tooth every 60 months, age 19 and younger)	Adult - 100% no deductible No waiting period Children - 100% after deductible No waiting period	Adult - 70% after deductible No waiting period Children - 70% after deductible No waiting period

Dental care services (continued)

	In-network coverage	Out-of-network coverage†
Class II - General, Restorative, and Surgical • Minor restorative services • Fillings (limit one per tooth every 24 months, composite covered on front teeth only)[2] • Simple and complex oral surgery • Extractions • Excision of benign lesion • Palliative treatment of dental pain – per visit	Adult - 60% after deductible 6 month waiting period Children - Not covered	Adult - 60% after deductible 6 month waiting period Children - Not covered

Pediatric Essential Health Benefits[3]

Children age 19 and younger

Class III- Major Restorative, Endodontic, Periodontic, and Prosthodontic Services • Resin onlays, inlays and crowns • Crowns • Bridgework • Dentures including repair and adjustments • Periodontics such as periodontic cleanings and gum therapies • Endodontics (root canals) • Root extraction	Adult - Not covered Children - Not covered	Adult - Not covered Children - Not covered
Class IV - Medically Necessary[3] • Orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palate with or without cleft lip	Adult - Not covered Children - Not covered	Adult - Not covered Children - Not covered

* Based on Humana network data, last accessed October 2023.

† Out-of-network dentists can bill you for charge above the amount covered by your Humana Smart Choice dental plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network. You can find dentists in the network by visiting **Humana.com/Find-Care**. waiting periods and other limitations may apply; please see your policy for coverage details.

An individual covered family member will receive benefits for covered services once they have met their individual deductible. The rest of the covered family members will receive benefits for covered services once they have met their individual deductible. The annual maximum benefit for each adult covered family member is shown above. Children age 19 and younger covered on the policy do not have an annual maximum.

Footnotes

1. "Gum Diseases and Other Diseases," American Academy of Periodontology, last accessed Oct. 12, 2023, 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.

3. Class III Pediatric Essential Health Benefits and Class IV Medically Necessary are covered benefits for children age 19 and younger.

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 has coverage under any worker's 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 U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
    a. War or any act of war, whether declared or not;
    b. Taking part in a riot, when the covered person is a voluntary participant;
    c. Commission of or an attempt to commit a criminal act, when the covered person is a voluntary participant;
    d. Any act of armed conflict; or
    e. 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. Any service 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. We consider the following cosmetic dentistry procedures:
    a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
    b. Any service performed primarily to improve appearance; or
    c. Characterizations and personalization of prosthetic devices.
7. Charges for:
    a. Any type of implant and all related services, including crowns or the prosthetic device attached to it including the removal of implants, unless specified in the policy;
    b. Precision or semi-precision attachments;
    c. Overdentures and any endodontic treatment associated with overdentures; or
    d. Other customized attachments.
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. 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 "Adult Dental Benefit" and "Pediatric Dental Benefit" section, as applicable.
12. Any service that we determine:
    a. Is not an eligible benefit based on clinical review;
    b. Does not offer a favorable prognosis;
    c. Does not have uniform professional endorsement; or
    d. Is deemed to be experimental or investigational in nature.
13. Orthodontic services unless otherwise stated in this policy. Mail order self-administered orthodontics, not under the direction of a provider, are not covered.
14. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under the policy terminates.
15. Services provided by someone who ordinarily lives in the covered person's home or who is a family member.

Limitations and exclusions (continued)

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:

16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Local anesthetics, irrigation, nitrous oxide/analgesia, bases, pulp caps, pulp testing, temporary dental services, study models/diagnostic casts, treatment plans, tissue preparation associated with the impression or placement of a restoration when charged as a separate service and desensitizing medicaments. 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 unless otherwise stated in the policy; 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. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
23. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
24. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
25. Partial ostectomy/sequestrectomy for removal of non-vital bone.

Pediatric 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 expense arising from the completion of forms.
2. Any service 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. We consider the following cosmetic dentistry procedures:
    a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
    b. Any service performed primarily to improve appearance; or
    c. Characterizations and personalization of prosthetic devices.
3. Charges for:
    a. Any type of implant and all related services, including crowns or the prosthetic device attached to it including the removal of implants, unless specified in the policy;
    b. Precision or semi-precision attachments;
    c. Overdentures and any endodontic treatment associated with overdentures;
    d. Other customized attachments;
    e. Any services for 3D imaging (cone beam images);
    f. Additional charges related to materials or equipment used in the delivery of dental care; or
    g. Charges for treatment rendered by family member or person who resides with the covered person.
4. Any service related to:
    a. Altering vertical dimension of teeth or changing the spacing and/or shape of the 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.
5. Orthodontic services.
6. Any non-emergent dental expenses incurred for services rendered outside of the United States.
7. Temporary and interim dental services.
8. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
9. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
10. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
11. Any services for orthognathic surgery.
12. Any services for destruction of lesions by any method.
13. Any services for tooth transplantation.
14. Any services for removal of a foreign body from the oral tissue or bone.
15. Any services generally considered to be medical services.
16. Any separate fees for pre and post-operative services.
17. 17. Integral service:
    a. Local anesthetics;
    b. Bases;
    c. Pulp caps;
    d. Pulp testing;
    e. Study models / diagnostic casts;
    f. Treatment plans;
    g. Nitrous oxide / analgesia;
    h. Irrigation;
    i. Desensitizing medicaments; and
    j. Tissue preparation associated with impression or placement of a restoration.
18. Limited and problem focused oral evaluations.
19. Detailed extensive oral evaluations.
20. Re-evaluation - limited problem focused.
21. Periodontic evaluations.

Pediatric limitations and exclusions (continued)

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:

22. Other X-rays including intra oral periapical & occlusal and extra oral x-rays only to diagnose specific treatment.
23. Space maintainers.
24. Re-cementation of space maintainer.
25. Removal of fixed space maintainer.

Insured by Humana Insurance Company.

Policy number: UT IND DEN 2019

Applications are subject to approval. Dental plans may have a minimum one-year initial contract period. 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.