Loyalty Plus

Individual Dental

Virginia

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 unless benefits payable under workers’ compensation are excluded from coverage. We will not exclude coverage for any covered service if an award of the Workers' Compensation Commission denies compensation benefits relating to such covered service and no request for review of such award is made within the time prescribed by § 65.2-705, or an award of the Workers' Compensation Commission, after review by the full Commission according to § 65.2-705, denies compensation benefits relating to such covered service. If these conditions are met, we will immediately provide coverage for the covered service to the extent otherwise covered under this policy.
2. Services:
    a. Performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance; or
    b. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.
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 or an attempt to commit a felony;
    d. 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; or
    g. Separate charges for materials or use of equipment, such as lasers.
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. Services not specifically listed in the “Schedule of Policy Benefits” section.
12. Services shown as “Not Covered” in the “Schedule of Policy Benefits” section.

Limitations and exclusions (continued)

13. Services that:
    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. Charges exceeding the reimbursement limit for the service.
17. 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
18. Repair or replacement of orthodontic appliances.
19. 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
20. Elective removal of non-pathologic impacted teeth.
21. Service for orthognathic surgery.
22. Services generally considered medical or covered by a medical plan.
23. Services for destruction of lesions by any method.
24. Services for tooth transplantation.
25. Services for removal of a foreign body from the oral tissue or bone.
26. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
27. Any separate fees for pre and post-operative care.
28. Replacement of restorations (fillings) placed less than two years ago.
29. 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: VA-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.