

About your plan

Good health starts with a healthy mouth. Regular dental exams and cleanings can lower the risk of gum disease, which is linked to heart disease, diabetes, stroke, and other serious conditions.

The Humana Dental Smart Choice plan is designed for individuals and families who believe in the importance of regular dental care. Members can maximize benefits by choosing one of the more than **225,000 dentist** locations in the The Humana Dental PPO network. There's no age requirement and you'll never be turned away for pre-existing conditions. Your plan year starts your first month of eligibility so you know you're getting the best value for your money.

You can find dentists in the network by visiting Humana.com.

Who can enroll for this plan : Any individual or family can apply for this plan. There are only three requirements: You must live in the U.S., you must be U.S. citizens or national (or lawfully present), and you cannot be currently incarcerated. (<http://www.healthcare.gov/marketplace/about/eligibility>)

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

The Humana Dental Smart Choice Plan is a Qualified Dental Health Plan insured by The Dental Concern, Inc., an issuer in kynect: Kentucky's Healthcare Connection.

How your plan works

	Adult	Family	Pediatric
Annual deductible This is the amount you will pay out-of-pocket for basic services in the plan (excludes discount services) ¹	\$50	\$50 per adult \$35 per child	\$35
Annual maximum This is the maximum amount that the plan will pay during the plan year (excludes discount services) ¹	\$1,000	\$1,000 per individual adult family member	No Annual Maximum
Maximum Out Of Pocket	Out of pocket maximum for a policy with one covered child is \$350. The out of pocket maximum for a policy with two or more covered children is \$350 per individual child or \$700 combined for all children.		

Coinsurance options	In-network coverage	Out-of-network coverage
Class I – Diagnostic and Preventive		
<ul style="list-style-type: none"> Routine oral examinations (limit 2 per year) Periodic examinations (limit 2 per year) Bitewing X-rays (limit one set per year) Cleanings (limit 2 per year) Topical fluoride treatment (limit two per year) Sealants (limit 1 every 4 year period for six and twelve year molars with a lifetime limit of three sealants per tooth, ages 21 and younger) 	Adult – 100% no deductible Children – 100% after par deductible No waiting period	75% after deductible No waiting period

Humana Dental Smart Choice

<p>Class II – General, Restorative, and Surgical</p> <ul style="list-style-type: none"> • Minor restorative services: • Fillings (composite covered on front teeth only)² • Simple and complex oral surgery • Extractions • Excision of benign cyst or tumor • Emergency care for pain relief³ 	<p>50% after deductible Children – no waiting period Adults – 6 month waiting period</p>	<p>50% after deductible Children – no waiting period Adults – 6 month waiting period</p>
<p>Pediatric Essential Health Benefits³ Children through age 21</p>		
<p>Class III – Major Restorative, Endodontic, Periodontic, and Prosthodontic Services</p> <ul style="list-style-type: none"> • Dentures including repair and adjustments • Periodontics such as periodontic cleanings and gum therapies • Endodontics (root canals) • Root extraction 	<p>50% after deductible no waiting period</p>	<p>50% after deductible no waiting period</p>
<p>Class IV – Medically Necessary³</p> <ul style="list-style-type: none"> • Orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palette with or without cleft lip (limit one per lifetime) 	<p>50% after deductible no waiting period</p>	<p>50% after deductible no waiting period</p>

Out-of-network dentists can bill you for charges above the amount covered by your Humana Dental Smart Choice plan. To ensure you do not receive additional charges, visit a dentist in the Humana Dental PPO network. You can find dentists in the network by visiting Humana.com. Waiting periods and other limitations may apply; please see your policy for coverage details.

An individual covered family member will receive coinsurance benefits once they have met their individual deductible. The rest of the covered family members will receive coinsurance benefits once they have met their individual deductible. The annual maximum benefit for each adult covered family member is \$1,000. Children through age 21 covered on the policy do not have an annual maximum.

1. Network providers are not required to offer non-covered services at a discounted rate. Humana encourages all providers to extend discounts, but cannot legally require. Check with in-network provider for details.
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 through age 21.

Dental limitations and exclusions

This is an outline of the limitations and exclusions for the policy listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Some of the services not covered include those:
 - a. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. 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. Any act of international armed conflict; or
 - c. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the provider.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are 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 to correct congenital malformation;
 - c. Any service performed primarily to improve appearance; or
 - d. Characterizations and personalization of prosthetic devices.
7. Charges for:
 - a. Precision or semi-precision attachments;
 - b. Overdentures and any endodontic treatment associated with overdentures;
 - c. Other customized attachments.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - c. 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 or similar 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. Any service not specifically listed in your policy.
14. Any service that we determine:
 - a. Is not an eligible benefit based on clinical review of the policy;
 - 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.
15. Orthodontic services unless otherwise stated in the policy.
16. Any expense incurred before your effective date or after the date your coverage under the policy terminates.
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. 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.
21. Repair and 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 unless otherwise stated in the policy; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Periapical and bitewing X-rays will not be covered in the same twelve month period as an intraoral complete X-ray series.
25. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
26. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
27. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Pediatric dental limitations & exclusions

Additional expenses not covered for the following benefits:

Pediatric dental

1. Charges for:
 - a. Any services for 3D imaging (cone beam images).
 - b. Additional charges related to materials or equipment used in the delivery of dental care.
 - c. Charges for treatment rendered by family member or person who resides with the covered person.
2. Any service related to changing the spacing and/or shape of the teeth.
3. Any non-emergent dental expenses incurred for services rendered outside of the United States.
4. Temporary and interim dental services.
5. Preventive control programs including, or similar to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
6. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
7. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
8. Any services for orthognathic surgery.
9. Any services for destruction of lesions by any method.
10. Any services for tooth transplantation.
11. Any services for removal of a foreign body from the oral tissue or bone.
12. Any services generally considered to be medical services.
13. Any separate fees for pre and post-operative services.

Humana brand dental products are insured by the Dental Concern, Inc.

Applications are subject to approval. Waiting periods, limitations and exclusions apply. This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

Policy number: KY HUMD IND 2014

