Preventive Plus

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 Preventive Plus dental plan is designed for people who believe in the importance of regular dental exams and cleanings. With no office visit copayments, the plan offers coverage for preventive and basic services like routine cleanings and exams, fillings, and extractions. Members can maximize benefits by choosing one of the more than 135,000 dentists and specialists* in our nationwide network. Visit **Humana.com/Find-Care** to find a participating dentist.

Who can enroll in this plan – Anyone can enroll in this plan.

How your plan works

Calendar year deductible	Individual	Family
This is the dollar amount you pay for covered services each calendar year before the plan pays	$50	$150

Annual maximum	
This is the maximum amount that the plan will pay in a calendar year for covered services	$1,000 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 per calendar year) • Comprehensive oral evaluation (limit two per calendar year) • Bitewing X-rays (limit one set, up to four films, every calendar year, excludes full mouth and panoramic) • Cleanings (limit two per calendar year) • Topical fluoride treatment (limit one per calendar year, age 14 and younger) • Sealants (limit of one per tooth per lifetime, age 14 and younger)	100% no deductible	70% after deductible
Basic services (6 month elimination period‡) • Extractions and root removal • Fillings (limit two per calendar year, composite covered on front teeth only[2]) • Space maintainers (age 14 and younger, initial placement only, not covered on permanent teeth) • Oral surgery • Prefabricated stainless steel crowns	50% after deductible	30% after deductible
• Palliative treatment of dental pain – per visit	50% after deductible	50% after deductible

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* Based on Humana network data, last accessed October 2024.

† Out-of-network dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network. Elimination periods‡ and other limitations may apply; please see your policy for coverage details.

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

Important to know: Dental plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. 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. 11, 2024, 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. 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:
    a. While on active duty as a member of the armed forces of any nation; or
    b. War or any act of war, whether declared or not.
4. 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.
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;
    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.
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. Any service not specifically listed in the “Schedule of Policy Benefits” section.
12. Any service shown as “Not Covered” in the “Schedule of Policy Benefits” section.

Limitations and exclusions (continued)

13. 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.
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. Services provided by someone who ordinarily lives in the covered person's home or is a family member.
17. Charges exceeding the reimbursement limit for the service.
18. Treatment results from any intentionally self inflicted bodily injury.
19. 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.
20. Repair or replacement of orthodontic appliances.
21. 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.
22. Elective removal of non-pathologic impacted teeth.
23. Service for orthognathic surgery.
24. Services generally considered medical or covered by a medical plan.
25. Any services for destruction of lesions by any method.
26. Any services for tooth transplantation.
27. Any services for removal of a foreign body from the oral tissue or bone.
28. Any services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
29. Any separate fees for pre and post-operative care.
30. Replacement of restorations (fillings) placed less than two years ago.

Insured by Humana Insurance Company.

Policy number: PA-71025 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.