Humana®
Dental Smart Choice

Tennessee Lite Plan

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.[1]

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 **270,000 dentist** locations in the Humana Dental PPO 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.

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. (https://www.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 Dental Smart Choice Plan is a Qualified Dental Health Plan insured by Humana Insurance Company, an issuer in the Health Insurance Marketplace.

How your plan works

Annual deductible Annual deductible This is the amount you will pay out-of-pocket for basic services in the plan (excludes discount services)[2]	Adult	Family	Pediatric
	$50	$50 per adult $25 per child	$25
Annual maximum Annual maximum This is the maximum amount that the plan will pay during the calendar year (excludes discount services)[2]	$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 • Routine oral examinations (limit 2 per year) • Periodic examinations (limit 2 per year) • Bitewing X-rays (limit two sets per year, excludes full mouth and panoramic) • Cleanings (limit 2 per year) • Topical fluoride treatment (limit two per year, age 19 and under) (topical fluoride varnish ages 0-5 100% no deductible) • Sealants (limit 1 per tooth per 3 years, age 19 and under)	Adult - 100% after deductible Child - 100% after deductible No waiting period	70% after deductible No waiting period

Humana®

Health Insurance Marketplace

Humana Dental Smart Choice

Pediatric Essential Health Benefit[4]
Children through age 19

Class II – General, Restorative, and Surgical • Minor restorative services: • Fillings (composite covered on front teeth only)[3] • Simple and complex oral surgery • Extractions • Excision of benign cyst or tumor • Emergency care for pain relief	50% after deductible No waiting period	50% after deductible No waiting period
Class III – Major Restorative, Endodontic, Periodontic, and Prosthodontic Services • Resin onlays, inlays and crowns (limit 1 per tooth per 5 years; permanent teeth only) • Crowns • Bridgework • Dentures including repair and adjustments • Periodontics such as periodontic cleanings and gum therapies • Endodontics (root canals) • Root extraction	50% after deductible No waiting period	50% after deductible No waiting period
Class IV – Medically Necessary[4] • 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	50% after deductible No waiting period	50% after deductible No waiting period

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 19 covered on the policy do not have an annual maximum.

1. American Dental Association, Health Policy Institute, Oral Health and Well-being in the United States.

   www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being?source=PromoSpots&Medium=ADAHPIRotator&conent=HPIWell-Being

2. Network providers are not required to offer non-covered services at a discounted rate. Humana Dental encourages all providers to extend discounts, but cannot legally require. Check with in-network provider for details.
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.
4. Class III Pediatric Essential Health Benefits and Class IV Medically Necessary are covered benefits for children through age 19.

Dental limitations and exclusions

In addition to the limitations and exclusions listed in "Adult Dental Benefit" and "Pediatric Dental Benefit" sections, as applicable, 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.
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 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. 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 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.
7. Charges for:
   a. Precision or semi-precision attachments;
   b. Overdentures and any endodontic treatment associated with overdentures; or
   c. 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. 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. Any service not specifically listed in "Adult Dental Benefit" and "Pediatric Dental Benefit" section, as applicable.
14. 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.
15. Orthodontic services unless otherwise stated in this policy. Mail-order self-administered orthodontics, not under the direction of a provider, are not covered.
16. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this policy terminates except as stated in the extension of benefits provision.
17. Services provided by someone who ordinarily lives in the covered person's 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 / analgesia, desensitizing medicaments, 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. 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 this 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. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
25. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
26. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
27. Partial ostectomy/sequestrectomy for removal of non-vital bone.

Pediatric dental limitations & exclusions

In addition to the LIMITATIONS AND EXCLUSIONS section and any exclusions listed in this "Pediatric Dental Benefits" section, the following limitations and exclusions also apply to pediatric dental benefits:

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 a covered person is covered under this policy. We consider the following procedures to be cosmetic dentistry:
   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 this 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.
   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 unless specified in this "Pediatric Dental Benefit" section.
6. Local anesthetics, irrigation, nitrous oxide/analgesia, bases, pulp caps, study models, treatment plans, desensitizing medicaments, 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.
7. Any non-emergent dental expenses incurred for services rendered outside of the United States.
8. Temporary and interim dental services.
9. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
10. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
11. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
12. Any services for orthognathic surgery.
13. Any services for destruction of lesions by any method.
14. Any services for tooth transplantation.
15. Any services for removal of a foreign body from the oral tissue or bone.
16. Any services for reconstruction of surgical, traumatic or congenital defects of the facial bones.
17. Any services generally considered to be medical services.
18. Any separate fees for pre and post-operative services.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك