# Smart Choice - 2023

Individual Dental

## Illinois Lite Plan

**Counties:** Bond, Boone, Calhoun, Carroll, Clinton, Cook, DeKalb, DuPage, Greene, Grundy, Jersey, Jo Daviess, Kane, Kankakee, Kendall, Lake, Lee, Macoupin, Madison, McHenry, Monroe, Montgomery, Ogle, Randolph, St Clair, Stephenson, Washington, Will, and Winnebago

## 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 325,000 dentist locations in the HumanaDental® 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** 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**<br>This is the amount you will pay out-of-pocket for basic services in the plan (excludes discount services) [2] | $60 | $60 per adult<br>$25 per child | $25 |
| **Annual maximum**<br>This is the maximum amount that the plan will pay during the calendar year (excludes discount services) [2] | $1,000 | $1,000<br>per individual adult<br>family member | No annual maximum |

**Maximum Out of Pocket**

Out of pocket maximum for a policy with one covered child is $375. The out of pocket maximum for a policy with two or more covered children is $375 per individual child or $750 combined for all children.

| Coinsurance options | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Class I - Diagnostic and Preventive**<br>• Routine oral examinations (limit two per year)<br>• Periodontal examinations (limit two per year)<br>• Bitewing X-rays (limit two sets per year, excludes full mouth and panoramic)<br>• Cleanings (limit two per year)<br>• Topical fluoride treatment (limit two per year, age 19 and under) (topical fluoride varnish ages 0-5, 100% no deductible<br>• Sealants (limit one per tooth per three years, age 19 and under) | Adult -<br>100% after deductible<br>No waiting period<br><br>Children -<br>100% after deductible<br>No waiting period | Adult -<br>70% after deductible<br>No waiting period<br><br>Children -<br>70% after deductible<br>No waiting period |

Humana®

Health Insurance Marketplace

| Coinsurance options continued | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Class II - General, Restorative, and Surgical**<br>• Minor restorative services<br>• Fillings (composite covered on front teeth only) [3]<br>• Simple and complex oral surgery<br>• Extractions<br>• Excision of benign cyst or tumor<br>• Emergency care for pain relief | Adult -<br>Not covered<br><br>Children -<br>50% after deductible<br>No waiting period | Adult -<br>Not covered<br><br>Children -<br>50% after deductible<br>No waiting period |

## Pediatric Essential Health Benefits [4]
### Children through age 19

| | | |
|---|---|---|
| **Class III - Major restorative, Endodontic, Periodontic, and Prosthodontic Services**<br>• Resin onlays, inlays and crowns (limit one per tooth per five years; permanent teeth only)<br>• Crowns<br>• Bridgework<br>• Dentures including repair and adjustments<br>• Periodontics such as periodontic cleanings and gum therapies<br>• Endodontics (root canals)<br>• Root extraction | Adult -<br>Not covered<br><br>Children -<br>50% after deductible<br>No waiting period | Adult -<br>Not covered<br><br>Children -<br>50% after deductible<br>No waiting period |
| **Class IV - Medically Necessary [4]**<br>• 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 -<br>Not covered<br>Children -<br>50% after deductible<br>No waiting period | Adult -<br>Not covered<br>Children -<br>50% after deductible<br>No waiting period |

Out-of-network dentists can bill you for charges above the amount covered by your Humana Smart Choice dental plan. To ensure you do not receive additional charges, visit a dentist in the HumanaDental® 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 $1000. Children through age 19 covered on the policy do not have an annual maximum.

**Footnotes:**

[1] "Gum Diseases and Other Diseases," American Academy of Periodontology, last accessed July 10, 2022, https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/

[2] Network providers are not required to offer non-covered services at a discounted rate. HumanaDental® encourages 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

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 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 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 expense arising from the completion of forms.
4. Failure to keep an appointment with the provider.
5. 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.
6. 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; or
   d. Other customized attachments;
7. 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 stablize periodontally weakened teeth;
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   e. Bite registration or bite analysis.
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 "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-administrered 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.
16. Charges exceeding the reimbursement limit for the service.
17. Local anesthetics, irrigation, nitrous oxide/analgesia, desensitizing medicaments, bases, pulp caps, pulp tests, temporary dental services, study models, treatment plans, tissue preparation associated with the impression or placement of a restoration when charged as a separate service. Unless otherwise stated in this policy, these services are considered an integral part of the entire dental service.
18. Repair or replacement of orthodontic appliances.

## Dental 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:

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 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.
20. Elective removal of non-pathologic impacted teeth.
21. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
22. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
23. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
24. Partial ostectomy/sequestrectomy for removal of non-vital bone.

## Pediatric dental 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.
   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 the “pediatric dental benefit” section.
6. Local anesthetics, irrigation, nitrous oxide/analgesia, bases, pulp caps, pulp testing, study models/diagnostic casts, treatment plans, desensitizing medicaments 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.

## Pediatric dental 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:

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.



Policy number: IL HUMD IND 2023 P

Humana®

# 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, ethnicity, marital status, religion, or language. 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 **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, **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: **800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 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. 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

GCHJV5REN 0721