Humana®
Dental Smart Choice

Illinois High 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.

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 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

	Adult	Family	Pediatric
Annual deductible Annual deductible This is the amount you will pay out-of-pocket for basic services in the plan (excludes discount services)[1]	$25	$25 per adult $50 per child	$50
Annual maximum Annual maximum This is the maximum amount that the plan will pay during the calendar 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 • 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, age 19 and under) (topical fluoride varnish ages 0-5 100% no deductible) • Sealants (limit 1 per tooth per lifetime, age 19 and under)	100% no deductible No waiting period	Adult - 70% after deductible Children - 100% no deductible No waiting period

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Class II – General, Restorative, and Surgical • 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 relief[3]	Adult - 70% after deductible Children - 80% after deductible Children - no waiting period Adults - 6 month waiting period	Adult - 50% after deductible Children - 80% after deductible Children - no waiting period Adults - 6 month 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 • Periodontics such as periodontic cleanings and gum therapies (child only through age 19) • Endodontics (root canals) • Root extraction	50% after deductible Adults - 12 month waiting period Child - no waiting period	50% after deductible Adults - 12 month waiting period Child - 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. 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.
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. Emergency care covered at 50 percent both in-network and out-of-network in state of Illinois (IL).
4. 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 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 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.
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 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.
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 "Adult Dental Benefit" and "Pediatric Dental Benefit" section, as applicable.
12. Any service that:
    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.
14. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this 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, 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.
18. Repair and 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 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.
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 & 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. Precision or semi-precision attachments.
    b. Overdentures and any endodontic treatment associated with overdentures.
    c. Other customized attachments.
    d. Any services for 3D imaging (cone beam images).
    e. Additional charges related to materials or equipment used in the delivery of dental care.
    f. 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, bases, pulp caps, 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.
7. Any non-emergent dental expenses incurred for services rendered outside of the United States.
8. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
9. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance except when the appliance or prosthetic is over five years old, or when medically necessary.
10. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
11. Any services for tooth transplantation.
12. Any separate fees for pre and post-operative services.

Insured by Humana Insurance Company.

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: IL HUMD IND 2017

Humana®

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY：711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY：711)。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).

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