

Complete

Individual Dental

Colorado

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 Complete dental plan is designed for people who are looking to maintain their oral health through regular dental exams and cleanings. The plan offers affordable coverage for preventive, basic and major services like routine cleanings and exams, fillings, dentures and extractions. You can lower your cost by choosing one of the more than 270,000 dentist locations in the Humana Dental PPO network. You can visit [Humana.com](https://www.humana.com) to find a participating specialist.

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

How your plan works

Calendar year deductible

This is the amount you will pay out-of-pocket for services in a calendar year

Individual

\$50
(deductible waived for in-network preventive services)

Family

\$150
(deductible waived for in-network preventive services)

Annual maximum

This is the maximum amount that the plan will pay in a calendar year

\$1,250 year one; \$1,500 year two and after, per individual on the plan

Coinsurance options

In-network coverage

Out-of-network coverage

Preventive services (no waiting period)

- Routine oral examinations (limit 2 per year)
- Limited oral evaluation (limit 1 per year)
- Comprehensive oral evaluation (limit 1 per 3 years)
- Bitewing X-rays (1 set of films per year for covered persons under age 10 and up to 4 films per year for covered persons age 10 and older)
- Panoramic film combined with Full Mouth (limit 1 every 5 years, age 12 and up)
- Cleanings (limit 2 per year)
- Topical fluoride treatment (limit 2 per year)
- Sealants (limit of 1 per tooth per lifetime, age 14 and under)

100% no deductible

100% after deductible

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Complete

Coinsurance options	In-network coverage	Out-of-network coverage
<p>Basic services (six-month waiting period applies - policyholders who provide proof of 12 months prior coverage are exempt from this waiting period.¹)</p> <ul style="list-style-type: none"> • Emergency care for pain relief • Extractions and root removal • Fillings (limit 1 per tooth, per 2 years, composite covered on front teeth only²) • Space maintainers (age 14 and under, initial placement only) • Prefabricated stainless steel crowns 	80% after deductible	80% after deductible
<p>Major services (twelve-month waiting period applies - policyholders who provide proof of 12 months prior coverage are exempt from this waiting period.¹)</p> <ul style="list-style-type: none"> • Endodontics - Root canals (limit 1 per lifetime, per tooth) • Complete dentures (limit 1 per 5 years) • Partial dentures (limit 1 per 5 years) • Denture repair and adjustments • Crowns (limit 1 per tooth per 5 years) • Onlays and Inlays (limit 1 per tooth per 5 years) • Oral surgery • Periodontal maintenance (limit 2 per year) - no waiting period for this service. • Periodontal scaling and root planing (limit 1 per quadrant every 3 years) - no waiting period for this service. 	50% after deductible	50% after deductible

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 the Humana Dental PPO Network. Waiting periods and other limitations may apply; please see your policy for coverage details.

This plan does not meet minimal essential coverage requirements for pediatric dental services as part of the Essential Health Benefits in accordance with the Affordable Care Act (ACA) provisions. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage.

Footnotes

- ¹ Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount dental plans are not considered prior coverage.
- 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.

Dental limitations and exclusions

his 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 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 United States government-owned or operated hospital/institution/agency.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Taking part in a riot;
 - c. Commission of or an attempt to commit a criminal act;
 - d. Engaging in an illegal profession or occupation;
 - e. Any act of armed conflict; or
 - f. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. Services 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.
7. 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.
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, prophylaxis, full mouth debridement and local anesthesia 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 anesthesiologist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Services not specifically listed in the "Schedule of Benefits (Who Pays What)" section.
14. Services shown as "Not Covered" in the "Schedule of Benefits (Who Pays What)" section.
15. 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.
16. Orthodontic services.
17. Any expense incurred before the covered person's effective date or after the date the covered person's coverage under this policy terminates.
18. Services provided by someone who ordinarily lives in the covered person's home or is a family member.
19. Charges exceeding the reimbursement limit for the service.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans 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 or 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 or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Service for orthognathic surgery.
25. Services generally considered medical or covered by a medical plan.
26. Services for destruction of lesions by any method.
27. Services for tooth transplantation.
28. Services for removal of a foreign body from the oral tissue or bone.
29. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
30. Any separate fees for pre and post-operative care.
31. Replacement of restorations (fillings) placed less than two years ago.
32. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.

Insured by Humana Insurance Company

Applications are subject to approval. Waiting periods may apply; 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. For more information, go to **Humana.com** or contact your sales agent.

Policy number: CO-71145, et al.



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'déé', t'áá jiik'eh, éí ná hóló, námbuu ninaaltsoos yézhí, bee nées 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).