Humana Dental Traditional Preferred

PA TRP U&C+ 100/80/50
FELLOW TRAVELERS

PENNSYLVANIA

Services	In-network dentist Network: PPO/Traditional Preferred	Out-of-network dentist U&C 90
Deductible (excludes orthodontia services)	Individual: $50 Family: $150 Deductible applies to all services excluding preventive services.	Individual: $50 Family: $150
Annual maximum (excludes orthodontia services)	$1,500 + extended annual maximum (see section below)	
Preventive services **Routine oral examinations** (3 per year) **Bitewing x-rays** (2 films under age 10, up to 4 films ages 10 and older) **Panoramic x-rays** (1 per 5 years combined, Panorex and Full Mouth X-rays share the same frequency; ages 6+) **Routine cleanings** (3 per year) **Periodontal cleanings** (4 per year) **Fluoride treatment** (1 per year, through age 16) **Sealants** (permanent molars, through age 16) **Space maintainers** (primary teeth, through age 15) **Oral Cancer Screening** (1 per year, ages 40 and older)	100% no deductible	100% no deductible
Basic services **Emergency care for pain relief** **Amalgam fillings** (1 per tooth every 2 years, composite for anterior/front teeth) **Oral surgery** (including extractions of impacted teeth) **General anesthesia**[1] **Stainless steel crowns** **Harmful habit appliances for children** (1 per lifetime, through age 14) **Periodontics** (scaling/root planing and surgery 1 per quadrant every 3 years)	80% after deductible	80% after deductible

[1] Only covered in conjunction with covered oral surgical procedures. Other restrictions may apply.

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Major services **Crowns** (1 per tooth every 5 years) **Inlays/onlays** (1 per tooth every 5 years) **Bridges** (1 every 5 years) **Dentures** (1 every 5 years) **Denture relines/rebases** (1 every 3 years, following 6 months of denture use) **Denture repair and adjustments** (following 6 months of denture use) **Endodontics** (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible	50% after deductible
Extended Annual Max Additional coverage for preventive, basic, and major services after the annual maximum is met (excludes orthodontia)	30%	30%
Orthodontia services	Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.	

Humana will reimburse out-of-network claims based on internal and external data (including FairHealth industry benchmarks) to establish reimbursement limits by geographic region. Out of network dentists may bill members for charges above the amount covered by the dental plan.

Waiting periods

Enrollment type[2]	Group size	Preventive	Basic	Major[3]	Orthodontia
Employer sponsored initial enrollment, open enrollment, and timely add-on	2-4 enrolled employees	No	No	12 months[4]	24 months[4]
Employer sponsored initial enrollment, open enrollment, and timely add-on	5 or more enrolled employees	No	No	No	No
Voluntary initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months[4]	24 months[4]
Voluntary initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months[4]

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Enrollment type[2]	Group size	Preventive	Basic	Major[3]	Orthodontia

[2] Late applicant enrollment will have the following waiting periods: 12 months basic & major services, 12 months orthodontia (24 months for 2-9 enrolled employees.)
[3] Waiting periods do not apply to endodontic services unless a late applicant.
[4] Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.

Questions?

Visit **Humana.com** or call **866-427-7478**
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a dentist at **Humana.com/findadentist.**

Register today!

Register or sign in to MyHumana at **Humana.com** to view your coverage details, ID cards, manage claims, find a dentist and more!

Limitations and exclusions (all services):
In addition to the limitations and exclusions listed in **Your plan benefits section**, this policy does not provide benefits for the following:

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:
   - That are free or that you would not be required to pay for if you 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;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - 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:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   - Any service to correct congenital malformation;
   - Any service performed primarily to improve appearance;
   - Characterizations and personalization of prosthetic devices; or
   - Any procedure to change the spacing and/or shape of the teeth
7. Charges for:
   - Any type of implant and all related services;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments;
   - Any service for 3D imaging (cone beam images);
   - Temporary and interim dental services;
   - Additional charges related to material or equipment used in the delivery of dental care.
   - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer policyholder;
   - The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
   - Altering vertical dimension of teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
   - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than 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 Your plan benefits.
14. Any service that:
    - Is not eligible for benefits based upon clinical review;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional acceptance; or
    - Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

- continued on next page

16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Services provided by someone who ordinarily lives in your 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, 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.
21. Temporary dental services.
22. Repair and replacement of orthodontic appliances.
23. 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 expression and chewing functions, for symptoms including, but not limited to, headaches.
24. The oral surgery benefits under this plan does not include:
    a. Any services for orthognathic surgery;
    b. Any services for destruction of lesions by any method;
    c. Any services for tooth transplantation;
    d. Any services for removal of a foreign body from the oral tissue or bone;
    e. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
    f. Any separate fees for pre and post-operative care.
25. General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.

    General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
    1. Pain control unless a documented allergy to local anesthetic is provided.
    2. Anxiety.
    3. Fear of pain.
    4. Pain management.
    5. Emotional inability to undergo surgery.
26. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
27. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
28. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
29. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
30. We do not cover services that generally are considered to be medical services except those specifically noted as covered in this certificate.

Excess coverage
We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year.

Missing tooth clause: See plan document for more details.

Insured by Humana Insurance Company.

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

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