

HumanaDental

Illinois Prepaid Regulatory and Technical Information

Questions

We are known for our personal, easy-to-use service. Anytime there is a question about any portion of your plan, simply call or logon to www.humanadental.com. It's that easy!

For general questions about the plan call:

1-800-233-4013

8:00 a.m. to 6:00 p.m. Monday - Friday

A toll-free Telecommunication Device for the Deaf (TDD) line is available at 1.800.325.2025.

Definitions

Customary, Usual and Reasonable/Maximum Allowable Fee means the lesser of:

1. the fee most often charged in the geographical area where the service was performed;
2. the fee most often charged by the provider;
3. the fee which is recognized as reasonable by a prudent person; or
4. the fee determined by comparing charges for similar services to a national data base adjusted to the geographical area where the services or procedures were performed.

Limitations and Exclusions

Exclusions

Covered services do not include and no coverage is available for:

1. any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain which:
 - a. benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or
 - b. coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually applied for;
2. services and supplies;
 - a. for which no charge is made, or for which you would not be required to pay if you did not have this coverage, 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 hospital or institution owned or operated by the United States Government or any of its agencies for any service-connected sickness or injury.
3. any loss caused or contributed to by;
 - a. war or any act of war, whether declared or not; or
 - b. any act of international armed conflict, or any conflict involving armed forces of any international authority;
4. completion of forms or failure to keep an appointment with the dentist;
5. replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prostheses, or appliance;
6. any service that we consider cosmetic dentistry, unless such service is necessary as a result of an accidental bodily injury sustained while you are covered under the plan. The following are examples of cosmetic dentistry:
 - a. facings on crowns or pontics posterior to the second bicuspid;
 - b. any service to correct congenital malformations;
 - c. characterizations and personalization of prosthetic devices; or
 - d. any service performed primarily to improve appearance;
7. preventive control programs including, but not limited to, plaque control, take home items, or dietary planning;
8. caries susceptibility testing, lab tests, anaerobic cultures, sensitivity testing;
9. any service related to:
 - a. altering vertical dimension;
 - b. restoration or maintenance of occlusion;
 - c. splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. replacing tooth structures as a result of abrasion, attrition, or erosion;
 - e. bite registration or bite analysis;

10. charges for:
 - a. implants of any type including any crowns or prosthetic device attached to it;
 - b. precision or semi-precision attachments;
 - c. overdentures and any endodontic treatment associated with it;
 - d. other customized attachments;
11. any hospital, surgical, or treatment facility or for services of an anesthesiologist or anesthetist;
12. general anesthesia unless administered by a dentist in conjunction with covered oral surgical procedures and is considered medically necessary. Patient management or apprehension does not constitute medical necessity;
13. prescription drugs or pre-medications whether dispensed or prescribed;
14. major services on other than permanent teeth. The following are considered major services:
 - a. endodontics—root canal therapy;
 - b. crowns;
 - c. inlays and onlays;
 - d. removable or fixed bridgework;
 - e. partial or complete dentures; or
 - f. denture relines or rebases;
15. any service or supply which:
 - a. is NOT a dental necessity;
 - b. does not offer a favorable prognosis;
 - c. does not have uniform professional endorsement; or
 - d. is deemed to be experimental in nature;
16. services that are generally considered to be medical services, except those specifically listed in your schedule of member copayments;
17. composite restorations on molar and bicuspid teeth. Alternate services will be applied allowing benefits for amalgam restorations;
18. surgical or non-surgical 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; treatment of the facial muscles, used in expression and mastication functions, for symptoms including, but not limited to, headaches;
19. any expense incurred prior to your effective date or after the date your coverage under the plan terminates, except for any extension of benefits;
20. any service or supply not specifically listed in your schedule of member copayments;
21. services provided by a person who ordinarily resides in your home or who is a family member;
22. treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane;
23. local anesthetics, irrigation, nitrous oxide, bases, temporary dental services, study models, treatment plans, or occlusal adjustments as a separate service. These services will be considered an integral part of the entire dental service;
24. replacement of any bridges, partials, dentures, inlays, onlays, crowns or other laboratory fabricated restorations inserted within five years of the date of the last placement. Replacement which is essential due to the extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, or accidental injury is an exception to this exclusion;
25. the initial placement of dentures, partials, or bridges if it includes the replacement of teeth missing prior to your effective date of coverage under this plan. (This exclusion shall not apply if the prostheses replaces a functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prostheses) which was extracted while you are covered under this plan);
26. services provided by someone other than the member's primary care dentist or a participating specialist as applicable and described in the certificate. The member is responsible for all costs for services provided by a non-participating provider, when provided without our prior approval, except as described in the emergency services provision;
27. removal of asymptomatic third molars (wisdom teeth). Routine removal of third molars for prophylactic, elective, or orthodontic reasons is not covered. A pathological condition must be present for participating specialist referral approval;
28. incremental costs associated with optional/elective materials including, but not limited to:
 - a. ceramic;
 - b. clear lingual brackets; or
 - c. other cosmetic appliances;
29. orthodontic services unless specified on your schedule of member copayments. This plan does not include the following as orthodontic benefits:
 - a. maxillofacial surgery;
 - b. treatment involving surgically exposing impacted teeth (e.g. maxillary cuspids);
 - c. myofunctional therapy;
 - d. micrognathia;
 - e. hormonal imbalances causing growth and development abnormalities;
 - f. treatment related to temporomandibular joint disturbances; or
 - g. mucogingival surgery—severing frenum attachment;
30. repair and replacement of orthodontic appliances;
31. orthodontic treatment, even if shown as a benefit on the schedule of member copayments, in the following cases:
 - a. to correct congenital or developmental conditions such as treatment of cleft palate, anodontia, or orthognathic surgery except as a secondary coverage to a medical or health care policy;
 - b. which would cause major restorative work which is not ordinarily performed under general dentistry;
 - c. if for retreatment of prior orthodontic problems;
 - d. if for patients with severe medical disabilities which may prevent satisfactory orthodontic results;

- e. if for “invisible braces;” or
 - f. if treatment is done by a non-participating dentist. When orthodontic treatment is in progress and has been started prior to the effective date of your coverage, to be covered under this plan you must have the subsequent treatment provided by a participating provider; and
32. full mouth rehabilitation and alteration of vertical dimensions of the jaw, including all restorative procedures (except fillings), appliances and services. A full mouth rehabilitation consists of five (5) or more units of either fixed or removable prosthetics.
- a. precious metal, such as gold, for all crowns, removable or fixed appliances;
 - b. precision partials; implants;
 - c. personalization and characterization;
12. Use of nitrous oxide analgesia is at the discretion of the provider and may not be available at all locations.
13. The participating provider shall have the right to refuse treatment to a member who continually fails to follow a prescribed course of treatment or who fails to pay the applicable copayment; and shall have the right to charge the member a copayment, if a charge is customarily made, for broken appointments with less than 24 hours notice, except in a dire emergency which precluded the member from providing such notice.

Limitations

The following reflect limitations to the covered services shown on your schedule of member copayments:

1. Prophylaxis (cleanings)—once every 6 months;
2. Topical fluoride:
 - a. once every 6 months; and
 - b. age 14 and under;
3. Sealants:
 - a. occlusal surface of permanent molars which are free of decay and restorations;
 - b. patients age 14 and under;
 - c. once per tooth per lifetime;
4. Oral exams—once every 6 months;
5. X-rays:
 - a. intraoral series (14 films) or panorex—once every 5 years;
 - b. bitewings—one set per year;
 - c. other x-rays—only to diagnose specific treatment;
6. Space maintainer—age 14 and under, initial appliance only;
7. Perio scaling/root planing—once per quadrant in a 3 year period;
8. Root canal therapy—once per tooth in a 2 year period;
9. Vital pulpotomy—deciduous teeth only;
10. Denture relines/rebases—once every 3 years;
11. This plan provides for crowns and replacement of missing teeth with complete or partial dentures or fixed bridges using standard procedures. Treatment involving the following procedures or materials is considered optional and if performed, the member shall be responsible for any additional fee for:

Limitations for Orthodontic Services

In addition to the exclusions and limitations listed in the certificate, the following applies to orthodontic services:

If the dependent was covered under a prior orthodontic plan and the coverage terminated on the day immediately before the effective date under this plan, benefits are payable up to the lesser of:

1. the benefits that would have been payable for orthodontic services under the prior orthodontic plan, reduced by any amount actually paid by the prior plan; or
2. the benefits payable for orthodontic services under this plan.

You and the dependent must remain eligible under this plan during the remaining portion of the orthodontic treatment.

There is a 12 month waiting period that must be satisfied with this plan prior to having orthodontic benefits available. This waiting period may be waived under certain circumstances if the dependent had orthodontic coverage under the prior plan.

Prior plan for this provision means the member’s previous dental plan which was in effect the day before the member’s effective date under this plan and is being replaced by this plan.



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