Our dental plans will make you smile

At Humana we want to help take care of you. Dental health is an important part of your overall well-being and Humana's dental benefits help make it easy to make your dental care a priority. When you sign up for a Humana dental plan, you're signing up for a healthier you.

Why sign up for dental benefits?

Preventive dental care, such as checkups and cleanings, help stop issues before they start, saving you time and money in the long run. And when you use an in-network dentist, **preventive care is at no additional cost to you.**

For years, doctors have recognized the link between oral health and whole-body health. **Routine teeth cleanings can help reduce your risk for heart disease, stroke and dementia.**

Plus, **caring for you is at the heart of everything we do,** so we make it easy for you to get the help you need – when you need it. Our service teams are always ready to help and answer your questions.

Humana Dental Custom PPO

MI PPO O.08K U&C FLEX 100/50/50

City of Detroit Retired Police Fire VEBA Plan One (Low)

MICHIGAN

Services	In-network dentist Network: PPO/Traditional Preferred		Out-of-network dentist U&C 90	
Deductible (excludes orthodontia services)	Individual: $0	Family: $0	Individual: $0	Family: $0
	Deductible applies to all services excluding preventive services.			
Annual maximum (excludes orthodontia services)	$1,000			
Preventive services **Routine oral examinations** (3 per year) **Bitewing x-rays** (2 per year) **Panoramic x-rays** (1 per 3 years combined frequency with full mouth x-rays; ages 6+) **Full mouth x-rays** (1 per 3 years, combined frequency with panoramic x-rays; ages 12+) **Routine cleanings** (3 per year) **Oral Cancer Screening** (1 per year, ages 40 and older)	100% no deductible, does not apply against annual maximum		75% no deductible, does not apply against annual maximum	
Basic services **Emergency care for pain relief** **Amalgam fillings** (1 per tooth every 2 years, composite for anterior/front teeth) **Composite fillings** (1 per tooth every 2 years, molar teeth) **Routine extractions** **General anesthesia**[1] **Stainless steel crowns** **Harmful habit appliances for children** (1 per lifetime, through age 14) **Oral Surgery** (including extractions of impacted teeth) **Periodontics** (periodontal cleanings 2 per year, scaling/root planing 1 per quadrant every 2 years and surgery 1 per quadrant every 3 years) **Endodontics** (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible		50% after deductible	

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

Humana Dental Custom PPO

MI PPO O.08K U&C FLEX 100/50/50

City of Detroit Retired Police Fire VEBA Plan One (Low)

MICHIGAN

Services	In-network dentist Network: PPO/Traditional Preferred	Out-of-network dentist U&C 90
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) **Implants** (crowns, bridges, and dentures each limited to 1 per tooth every five years)	50% after deductible	50% after deductible
Orthodontia services	Child orthodontia - Covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $800 lifetime orthodontia maximum.	

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

Voluntary funding: 10+ enrolled employees

Enrollment type[2]	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment, and timely add-on	No	No	No	12 months[3]

[2]Late applicant enrollment will have the following waiting periods: 12 months basic & major services, 12 months orthodontia.
[3]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 incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
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 to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal profession or occupation or other willful criminal activity as defined by state law.
   - "Willful criminal activity" also includes, but is not limited to, any of the following:
   - Operating a vehicle while intoxicated; or
   - Operating a methamphetamine laboratory.
   - "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

This exclusion does not apply to any sickness or bodily injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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 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.
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.

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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 Dental Custom PPO

MI PPO O1K U&C FLEX 100/80/50

City of Detroit Retired Police Fire VEBA Plan Two (High)

MICHIGAN

Services	In-network dentist Network: PPO/Traditional Preferred		Out-of-network dentist U&C 90	
Deductible (excludes orthodontia services)	Individual: $0	Family: $0	Individual: $0	Family: $0
	Deductible applies to all services excluding preventive services.			
Annual maximum (excludes orthodontia services)	$1,500			
Preventive services **Routine oral examinations** (3 per year) **Bitewing x-rays** (2 per year) **Panoramic x-rays** (1 per 3 years combined frequency with full mouth x-rays; ages 6+) **Full mouth x-rays** (1 per 3 years, combined frequency with panoramic x-rays; ages 12+) **Routine cleanings** (3 per year) **Oral Cancer Screening** (1 per year, ages 40 and older)	100% no deductible, does not apply against annual maximum		100% no deductible, does not apply against annual maximum	
Basic services **Emergency care for pain relief** **Amalgam fillings** (1 per tooth every 2 years, composite for anterior/front teeth) **Composite fillings** (1 per tooth every 2 years, molar teeth) **Routine extractions** **General anesthesia**[1] **Stainless steel crowns** **Harmful habit appliances for children** (1 per lifetime, through age 14) **Oral Surgery** (including extractions of impacted teeth) **Periodontics** (periodontal cleanings 2 per year, scaling/root planing 1 per quadrant every 2 years and surgery 1 per quadrant every 3 years) **Endodontics** (root canals 1 per tooth per lifetime and 1 re-treatment)	80% after deductible		50% after deductible	

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

Humana Dental Custom PPO

MI PPO O1K U&C FLEX 100/80/50

City of Detroit Retired Police Fire VEBA Plan Two (High)

MICHIGAN

Services	In-network dentist Network: PPO/Traditional Preferred	Out-of-network dentist U&C 90
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) **Implants** (crowns, bridges, and dentures each limited to 1 per tooth every five years)	50% after deductible	50% after deductible
Orthodontia services	Child orthodontia - Covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $1,000 lifetime orthodontia maximum.	

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

Voluntary funding: 10+ enrolled employees

Enrollment type[2]	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment, and timely add-on	No	No	No	12 months[3]

[2]Late applicant enrollment will have the following waiting periods: 12 months basic & major services, 12 months orthodontia.
[3]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?

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Register today!

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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 incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
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 to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal profession or occupation or other willful criminal activity as defined by state law.
   - "Willful criminal activity" also includes, but is not limited to, any of the following:
   - Operating a vehicle while intoxicated; or
   - Operating a methamphetamine laboratory.
   - "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

This exclusion does not apply to any sickness or bodily injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

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 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.
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.

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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 Dental Custom PPO

MICHIGAN

MI PPO U&C FLEX 100/90/80

City of Detroit Retired Police Fire VEBA Plan Three (Enhanced)

Services	In-network dentist Network: PPO/Traditional Preferred		Out-of-network dentist U&C 90	
Deductible (excludes orthodontia services)	Individual: $0	Family: $0	Individual: $0	Family: $0
	Deductible applies to all services excluding preventive services.			
Annual maximum (excludes orthodontia services)	$2,500			
Preventive services **Routine oral examinations** (3 per year) **Bitewing x-rays** (2 per year) **Panoramic x-rays** (1 per 3 years combined frequency with full mouth x-rays; ages 6+) **Full mouth x-rays** (1 per 3 years, combined frequency with panoramic x-rays; ages 12+) **Routine cleanings** (3 per year) **Oral Cancer Screening** (1 per year, ages 40 and older)	100% no deductible, does not apply against annual maximum		100% no deductible, does not apply against annual maximum	
Basic services **Emergency care for pain relief** **Amalgam fillings** (1 per tooth every 2 years, composite for anterior/front teeth) **Composite fillings** (1 per tooth every 2 years, molar teeth) **Routine extractions** **General anesthesia**[1] **Stainless steel crowns** **Harmful habit appliances for children** (1 per lifetime, through age 14) **Oral Surgery** (including extractions of impacted teeth) **Periodontics** (periodontal cleanings 2 per year, scaling/root planing 1 per quadrant every 2 years and surgery 1 per quadrant every 3 years) **Endodontics** (root canals 1 per tooth per lifetime and 1 re-treatment)	90% after deductible		80% after deductible	

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

Humana Dental Custom PPO

MI PPO U&C FLEX 100/90/80

City of Detroit Retired Police Fire VEBA Plan Three (Enhanced)

MICHIGAN

Services	In-network dentist Network: PPO/Traditional Preferred	Out-of-network dentist U&C 90
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) **Implants** (crowns, bridges, and dentures each limited to 1 per tooth every five years)	80% after deductible	50% after deductible
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

Voluntary funding: 10+ enrolled employees

Enrollment type[2]	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment, and timely add-on	No	No	No	Not available

[2]Late applicant enrollment will have the following waiting periods: 12 months basic & major services.

Questions?

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Sunday, 11 a.m. – 8 p.m., Eastern time.
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Register today!

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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 incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
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 to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal profession or occupation or other willful criminal activity as defined by state law.
   - "Willful criminal activity" also includes, but is not limited to, any of the following:
   - Operating a vehicle while intoxicated; or
   - Operating a methamphetamine laboratory.
   - "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

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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 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.
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
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18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
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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.