Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: HUMANA DENTAL INSURANCE COMPANY Plan Name: 2007 PPO
Policy Type: Preferred Provider Organization Insurer Phone #: 1-800-233-4013
Effective Date: **Beginning on or after 1/1/2022 Insurer Website**: **Humana.com**

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT HUMANA.COM OR CALL 1-800-233-4013.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	**In-Network per individual**	**Out-of-Network per individual**
Dental	$50	$50
Orthodontia	There is no deductible	There is no deductible

- The deductible applies to all services, including Preventive, unless the waive deductible rider was purchased. Excludes Orthodontia.
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$1,500	$1,500
Lifetime or Annual Maximum for Orthodontia	Not Covered	Not Covered

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Enrollment Type	Group Size	Preventative	Basic	Major [1]	Orthodontia [1]
Initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months [2]	24 Months [2]
Initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months [2] (no waiting period for employee sponsored)
Late applicant [3,4]	2 or more enrolled employees	No	12 months	12 months	12 months (24 months for 2-9 enrolled)

[1] Preventative Plus does not cover major or orthodontia services.

[2] Waiting periods may be decreased or waived based on the number of months the member has dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period

[3] Late applicants not allowed with open enrollment option

[4] Waiting periods do not apply to endodontic or periodontic services unless a late application

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive	0%	20%	2 per year (emergency and oral exams share frequency)
Bitewing X-ray	Preventive	0%	20%	1 set per year
Cleaning	Preventive	0%	20%	2 per year
Filling	Basic	20%	50%	1 per tooth per surface per two years
Extraction, Erupted Tooth or Exposed Root	Basic	20%	50%	
Root Canal	Basic	20%	50%	1 per tooth per two years
Scaling and Root Planing	Basic	20%	50%	1 per quadrant per three years
Ceramic Crown	Major	50%	50%	1 per tooth per five years (crowns, inlays, onlays and veneers share frequency)
Removable Partial Denture	Major	50%	50%	1 per five years, replacement limitation
Extraction, Erupted Tooth with Bone Removal	Basic	20%	50%	
Orthodontia	Orthodontia	Not Covered	Not Covered	Not Covered

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has an appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $250 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: $0	Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: 1500 Out-of-network: 1500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 50%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%

In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $90	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $70.00 **Out-of-network:** $150.00	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $500.00 **Out-of-network:** $725.00
Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Summary of what is not covered or subject to a limitation:	Oral Exam 2 per year Xrays (FMX) 1 per 5 years Routine Cleaning 2 per year	Summary of what is not covered or subject to a limitation:	1 per tooth per surface per two years	Summary of what is not covered or subject to a limitation:	1 per tooth per five years (crowns,inlays,onlays and veneers share frequency)