## Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

## Part I: GENERAL INFORMATION

**Insurer Name: Humana Insurance Company**
**Policy Type: Preferred Provider Organization**
**Effective Date**: **Beginning on or after 1/1/2022**
**Plan Name: 2014 INFS PPO**
**Insurer Phone #: 1-800-233-4013**
**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 except Preventive or 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 | $2,000 | $2,000 |
| 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% | Periodic Exam 2 per year |
| *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 lifetime |
| *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<br>Out-of-network: $550 | Total Cost of Care | In-network: $150<br>Out-of-network: $200 | Total Cost of Care | In-network: $1,300<br>Out-of-network: $1,750 |
| Deductible | In-network: $0<br>Out-of-network: $0 | Deductible | In-network: $50<br>Out-of-network: $50 | Deductible | In-network: $50<br>Out-of-network: $50 |
| Annual Maximum (Plan Will Pay) | In-network: $2,000<br>Out-of-network: $2,000 | Annual Maximum (Plan Will Pay) | In-network: $2,000<br>Out-of-network: $2,000 | Annual Maximum (Plan Will Pay) | In-network: $2,000<br>Out-of-network: $2,000 |
| Patient Cost (copayment or coinsurance) | In-network: 0%<br>Out-of-network: 20% | Patient Cost (copayment or coinsurance) | In-network: 20%<br>Out-of-network: 50% | Patient Cost (copayment or coinsurance) | In-network: 50%<br>Out-of-network: 50% |
| **In this example, Dana would pay** | **In-network:** $0 | **In this example, Sam would pay** | **In-network:** $70.00 | **In this example, Maria would pay** | **In-network:** $500.00 |

| **(includes copays/coinsurance and deductible, if applicable):** | **Out-of-network:** $90 | **(includes copays/coinsurance and deductible, if applicable):** | **Out-of-network:** $150.00 | **(includes copays/coinsurance and deductible, if applicable):** | **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: | Periodic Exam 2 per year<br>Xrays (FMX) 1 per 5 years<br>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) |