Humana

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Humana
Policy Type: PPO
Effective Date: Beginning on or after 07/01/2017
Plan Name: Complete Dental
Insurer Phone #: 866-537-0232 (TTY:711)
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 866-537-0232 (TTY:711).

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	**In-Network**		**Out-of-Network**	
Dental	Per Individual $50	Per Family $150	Per Individual $50	Per Family $150
Orthodontia	Not covered		Not covered	

- **The deductible for in-network preventive services is waived.**
- 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	$1,250 year one, per individual on the plan $1,500 year two and after, per individual on the plan	$1,250 year one, per individual on the plan $1,500 year two and after, per individual on the plan
Lifetime or Annual Maximum for Orthodontia	Not covered	Not covered

- **Annual maximum** is the maximum dollar amount your plan 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 plan 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

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **There is no waiting period for Preventive Services. Basic Services requires a 6-month waiting period. Major Services requires a 12-month waiting period.**

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 Services	0% no deductible	0% after deductible	Limit two per calendar year
Bitewing X-ray	Preventive Services	0% no deductible	0% after deductible	One set of films per calendar year for covered persons age 10 and younger and up to four films per calendar year for covered persons age 11 and older
Cleaning	Preventive Services	0% no deductible	0% after deductible	Limit two per calendar year
Filling	Basic Services	20% after deductible	20% after deductible	Limit one per tooth every two years, composite covered on front teeth only
Extraction, Erupted Tooth or Exposed Root	Basic Services	20% after deductible	20% after deductible	No limit
Root Canal	Major Services	50% after deductible	50% after deductible	Limit one per tooth per lifetime
Scaling and Root Planing	Major Services	50% after deductible	50% after deductible	Limit one per quadrant every three years
Ceramic Crown	Major Services	50% after deductible	50% after deductible	Limit one per tooth every five years
Removable Partial Denture	Major Services	50% after deductible	50% after deductible	Limit one every five years
Extraction,Erupted Tooth with Bone Removal	Major Services	50% after deductible	50% after deductible	No limit
Orthodontia				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 a Dental 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: $263.71 Out-of-network: $307.63	Total Cost of Care	In-network: $198.98 Out-of-network: $298.47	Total Cost of Care	In-network: $1,135.34 Out-of-network: $1,377.41
Deductible	In-network: $50.00 Out-of-network: $50.00	Deductible	In-network: $50.00 Out-of-network: $50.00	Deductible	In-network: $50.00 Out-of-network: $50.00
Annual Maximum (Plan Will Pay)	In-network: $1,250.00 year one; $1,500.00 year two and after Out-of-network: $1,250.00 year one; $1,500.00 year two and after	Annual Maximum(Plan Will Pay)	In-network: $1,250.00 year one; $1,500.00 year two and after Out-of-network: $1,250.00 year one; $1,500.00 year two and after	Annual Maximum(Plan Will Pay)	In-network: $1,250.00 year one; $1,500.00 year two and after Out-of-network: $1,250.00 year one; $1,500.00 year two and after
Patient Cost (copayment or coinsurance)	In-network: 0% no deductible Out-of-network: 0% after deductible	Patient Cost (copayment or coinsurance)	In-network: 20% after deductible Out-of-network: 20% after deductible	Patient Cost (copayment or coinsurance)	In-network: 50% after deductible Out-of-network: 50% after deductible

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable)	In-network $0.00 Out-of-network: $50.00	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable)	In-network: $79.80 Out-of-network: $99.70	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable)	In-network: $592.67 Out-of-network: $713.70
Summary of what is not covered or subject to a limitation	One FMX per calendar year, two exams and cleanings per calendar year	Summary of what is not covered or subject to a limitation	One tooth per two calendar years; six month waiting period	Summary of what is not covered or subject to a limitation	Once per tooth every five calendar years; 12 month waiting period

Notice of Non-Discrimination. Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc. provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us as well as provides free language assistance services to people whose primary language is not English, including qualified sign language interpreters and written information in other formats.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services, contact Humana Inc. and its subsidiaries at **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents: You may also call the 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). Hours of operation: 8 a.m. – 8 p.m., Eastern time. Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

These notices are available at **www.humana.com/legal/non-discrimination-disclosure** and **www.humana.com/legal/multi-language-support**. 11/2024