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 01/01/2026

Plan Name: Humana Family Dental PPO
Insurer Phone #: 866-822-6275 (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 866-822-6275 (TTY: 711).THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Adult (age 19 and older) $50 per individual Pediatric (up to age 19) $75 per individual $150 per family	Adult (age 19 and older) $50 per individual Pediatric (up to age 19) $75 per individual $150 per family
Orthodontia	Adult (age 19 and older) Not covered Pediatric (up to age 19) $75 per individual $150 per family	Adult (age 19 and older) Not covered Pediatric (up to age 19) $75 per individual $150 per family

- **The deductible applies to all services except Preventive & Diagnostic Services.**
- 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	Adult (age 19 and older) $1,500 Pediatric (up to age 19) No annual maximum	Adult (age 19 and older) $1,500 Pediatric (up to age 19) No annual maximum
Lifetime or Annual Maximum for Orthodontia	Adult (age 19 and older) Not covered Pediatric (up to age 19) No annual maximum	Adult (age 19 and older) Not covered Pediatric (up to age 19) No annual maximum

- **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. **Your dental benefit package has a 6 month waiting period for Major Services for Adults (age 19 and older). Policyholders who provide proof of prior comparable dental coverage may be exempt from this 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 & Diagnostic	Adult 0% no deductible Pediatric 0% no deductible	Adult 10% no deductible Pediatric 10% no deductible	Limit 1 every 6 months
Bitewing X-ray	Preventive & Diagnostic	Adult 0% no deductible Pediatric 0% no deductible	Adult 10% no deductible Pediatric 10% no deductible	Limit once per service date for single image; limit one set per 6 months per provider for 2 to 4 images

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Cleaning	Preventive & Diagnostic	Adult 0% no deductible Pediatric 0% no deductible	Adult 10% no deductible Pediatric 10% no deductible	Limit 1 every 6 months
Filling	Basic	Adult 20% after deductible Pediatric 20% after deductible	Adult 30% after deductible Pediatric 30% after deductible	Limit 1 per permanent tooth every 12 months
Extraction, Erupted Tooth or Exposed Root	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	
Root Canal	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	Adult: Once per tooth per lifetime, 6 month waiting period Pediatric: Once per tooth per lifetime
Scaling and Root Planing	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	Adult: One per quadrant every 24 months, 6 month waiting period Pediatric: One per quadrant every 24 months (limited to age 13 and older)

Common Dental Procedures	Category	In-Network	Out-of- Network	Benefit Limitations and Exclusions
Ceramic Crown	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	Limit 1 per permanent tooth every 5 years (ages 13 and older). Adult 6 month waiting period. For Limitations and Exclusions, refer to the Covered Services; Major Restorative Services section of your Certificate of Coverage.
Removable Partial Denture	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	Limit once every 5 years. Adult 6 month waiting period.
Extraction, Erupted Tooth with Bone Removal	Major	Adult 50% after deductible Pediatric 50% after deductible	Adult 50% after deductible Pediatric 50% after deductible	
Orthodontia	Orthodontia	Adult Not Covered Pediatric 50% after deductible	Adult Not Covered Pediatric 50% after deductible	Adult: Not covered Pediatric: For Limitations and Exclusions, refer to the Covered Services; Orthodontics section of your Certificate of Coverage.

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 (full mouth x-ray) and cleaning (Adult member)	Resin-based composite – one surface, posterior (Child member)	Crown – porcelain/ceramic substrate (Adult member)

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Total Cost of Care	In-network: $233.05 Out-of-network: $258.03	Total Cost of Care	In-network: $166.02 Out-of-network: $276.05	Total Cost of Care	In-network: $1,051.47 Out-of-network: $1,428.57
Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $75 Out-of-network: $75	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	N/A	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 10%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 30%	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: $0.00 Out-of-network: $25.80	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $93.20 Out-of-network: $135.31	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $550.73 Out-of-network: $739.28
Summary of what is not covered or subject to a limitation:	X-rays once per 6 months, exam/cleaning once per 6 months	Summary of what is not covered or subject to a limitation:	One per tooth per calendar year	Summary of what is not covered or subject to a limitation:	One crown per tooth per 5 years

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