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 02/01/2011

Plan Name: Loyalty Plus
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 $150	Individual + One $300	Per Family $450	Per Individual $150	Individual + One $300	Per Family $450
Orthodontia	Not covered			Not covered		

- **The deductible for 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	$1,000 year one; $1,250 year two; $1,500 subsequent years per individual on the plan	$1,000 year one; $1,250 year two; $1,500 subsequent years, 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. **This plan does not have any waiting periods.**

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	100% no deductible	100% no deductible	Limit two per plan year
Bitewing X-ray	Diagnostic & Basic Services	Year one – 40% after deductible	Year one - 40% after deductible	Limit one set per plan year

Bitewing X-ray	Diagnostic & Basic Services	Year two – 55% after deductible Subsequent years – 70% after deductible	Year two – 55% after deductible Subsequent years – 70% after deductible	Limit one set per plan year
Cleaning	Preventive Services	100% no deductible	100% no deductible	Limit two per plan year
Filling	Basic Services	Year one - 40% after deductible Year two – 55% after deductible Subsequent years – 70% after deductible	Year one - 40% after deductible Year two – 55% after deductible Subsequent years – 70% after deductible	Limit two per plan year, composite covered on front teeth only
Extraction, Erupted Tooth or Exposed Root	Basic Services	Year one –40% after deductible Year two – 55% after deductible Subsequent years – 70% after deductible	Year one - 40% after deductible Year two – 55% after deductible Subsequent years – 70% after deductible	Limit two per plan year
Root Canal	Major Services	Year one - 20% after deductible	Year one - 20% after deductible	Limit one per tooth per two plan years, permanent teeth only

Root Canal	Major Services	Year two – 30% after deductible Subsequent years – 50% after deductible	Year two – 30% after deductible Subsequent years – 50% after deductible	Limit one per tooth per two plan years, permanent teeth only
Scaling and Root Planing	Major Services	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Limit two per plan year
Ceramic Crown	Major Services	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Limit one per tooth per five plan years
Removable Partial Denture	Major Services	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Limit one per five plan years

Extraction,Erupted Tooth with Bone Removal	Major Services	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 50% after deductible	Year one - 20% after deductible Year two – 30% after deductible Subsequent years – 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: $150.10 Out-of-network: $175.10	Total Cost of Care	In-network: $181.88 Out-of-network: $181.88	Total Cost of Care	In-network: $1,018.89 Out-of-network: $1,251.64
Deductible	In-network: $150 Out-of-network: $150	Deductible	In-network: $150 Out-of-network: $150	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $1,000 year one; $1,250 year two $1,500 subsequent years Out-of-network: $1,000 year one; $1,250 year two $1,500 subsequent years	Annual Maximum (Plan Will Pay)	In-network: $1,000 year one; $1,250 year two $1,500 subsequent years Out-of-network: $1,000 year one; $1,250 year two $1,500 subsequent years	Annual Maximum(Plan Will Pay)	In-network: $1,000 year one; $1,250 year two $1,500 subsequent years Out-of-network: $1,000 year one; $1,250 year two $1,500 subsequent years

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: 0%	Patient Cost (copayment or coinsurance)	In-network: 60% year one; 45% year two; 30% subsequent years Out-of-network: 60% year one; 45% year two; 30% subsequent years	Patient Cost (copayment or coinsurance)	In-network: 80% year one; 70% year two; 50% subsequent years Out-of-network: 80% year one; 70% year two; 50% subsequent years
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $00	In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $169.13 year one; $164.35 year two $159.56 subsequent years Out-of-network: $169.13 year one; $164.35 year two $159.56 subsequent years	In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $845.11 year one; $758.22 year two $584.45 subsequent years Out-of-network: $1,031.32 year one; $921.15 year two $700.82 subsequent years
Summary of what is not covered or subject to a limitation:	One FMX per plan year, two exams and cleanings per plan year	Summary of what is not covered or subject to a limitation:	Limit two per plan year, composite covered on front teeth only	Summary of what is not covered or subject to a limitation:	Once per tooth every five plan years

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call 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)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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