

## Abilene ISD

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist*	
	Individual	Family	Individual	Family
<b>Calendar-year deductible</b> (excludes orthodontia services)	\$50	\$150	\$50	\$150
Deductible applies to all services excluding preventive services.				
<b>Calendar-year annual maximum</b> (excludes orthodontia services)	\$1,500 + extended annual maximum (see section below)			
<b>Preventive services</b>	100% no deductible, does not apply against annual maximum		100% no deductible, does not apply against annual maximum	
<ul style="list-style-type: none"> <li>• Routine oral examinations (3 per year)</li> <li>• Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older)</li> <li>• Routine cleanings (3 per year)</li> <li>• Periodontal cleanings (4 per year)</li> <li>• Fluoride treatment (1 per year, through age 16)</li> <li>• Sealants (permanent molars, through age 16)</li> <li>• Space maintainers (primary teeth, through age 15)</li> <li>• Oral Cancer Screening (1 per year, ages 40 and older)</li> </ul>				
<b>Basic services</b>	80% after deductible		80% after deductible	
<ul style="list-style-type: none"> <li>• Emergency care for pain relief</li> <li>• Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth)</li> <li>• Oral surgery (tooth extractions including impacted teeth)</li> <li>• Stainless steel crowns</li> <li>• Harmful habit appliances for children (1 per lifetime, through age 14)</li> <li>• Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years)</li> </ul>				
<b>Major services</b>	50% after deductible		50% after deductible	
<ul style="list-style-type: none"> <li>• Crowns (1 per tooth every 5 years)</li> <li>• Inlays/onlays (1 per tooth every 5 years)</li> <li>• Bridges (1 per tooth every 5 years)</li> <li>• Dentures (1 per tooth ever 5 years)</li> <li>• Denture relines/rebases (1 every 3 years, following 6 months of denture use)</li> <li>• Denture repair and adjustments (following 6 months of denture use)</li> <li>• Implants (crowns, bridges, and dentures each limited to 1 per tooth every five years)</li> <li>• Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)</li> </ul>				

## Humana Dental Traditional Plus High

	If you use an IN-NETWORK dentist	If you use an OUT-OF-NETWORK dentist*
<b>Extended Annual Max</b> Additional coverage for preventive, basic, and major services after the calendar-year maximum is met (excludes orthodontia)	30%	30%
<b>Orthodontia services</b>	Adult/child orthodontia. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: \$1,000 lifetime orthodontia maximum.	

**\*Out of Network Dentists** can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

### Waiting periods

#### Employer-sponsored funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	No
Late applicant <sup>1,2</sup>	No	12 months	12 months	12 months

<sup>1</sup> Late applicants not allowed with open enrollment option.

<sup>2</sup> Waiting periods do not apply to endodontic or periodontic services unless a late applicant.