Humana Individual Specialty Agent Plan Grid

- Dental plans
- Dental, vision, and hearing (DVH) plans
- Vision plans

Revised April 2025

WHAT'S NEW?

New state launch:

- Alaska: Complete Dental, Bright Plus, Bright Plus for Veterans

Plans added for new sales in multiple states:

- Arkansas: Humana Vision PLUS *(replaces Vision Care Plan (VCP) for new sales)*
- Idaho: Humana Vision PLUS *(replaces Focus for new sales)*
- New Mexico: Complete Dental, Humana Extend (2500, 5000)
- Virginia: Humana Extend (1250, 2500, 5000)
- Wyoming: Humana Vision PLUS *(replaces Focus for new sales)*

Be sure to access the most current benefit summaries, rate sheets, and paper applications included in this grid.

For Agent Use Only

Humana®

GCHK38JEN 0425

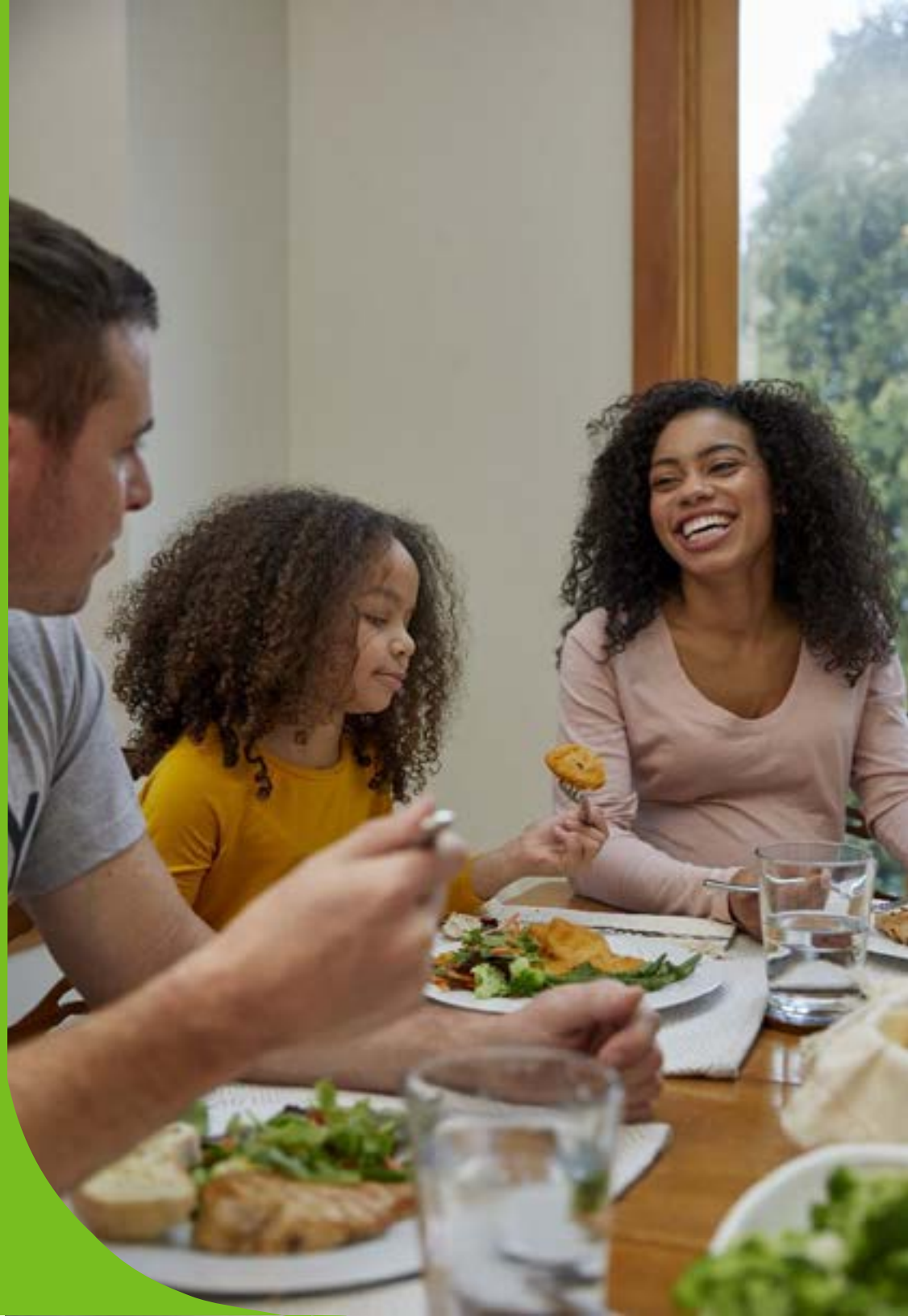


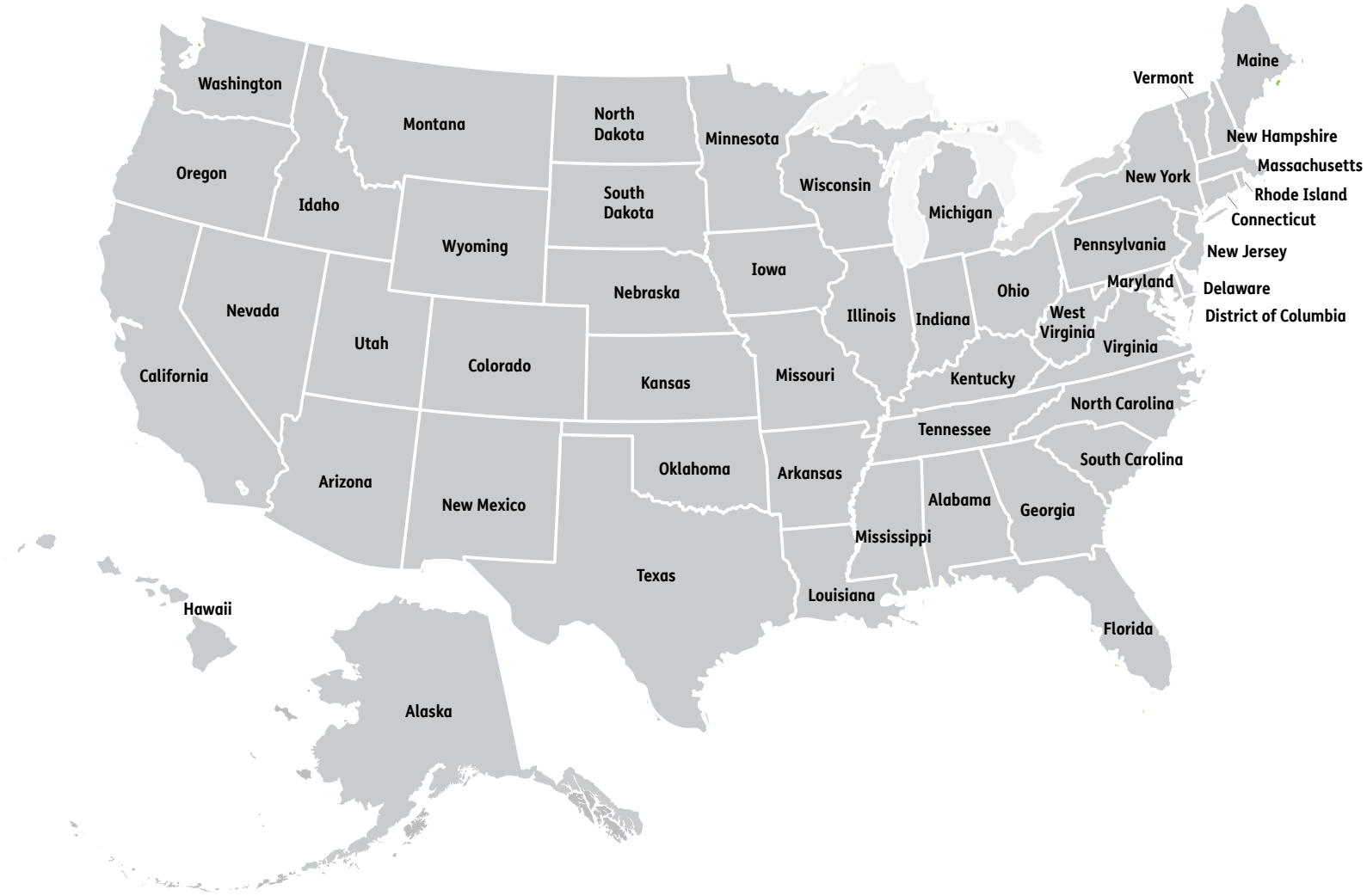
Table of Contents

Agent Plan Guide

Humana Individual Specialty

Click on a state to view:

- Dental plan options
- DVH plan options
- Vision plan options
- Benefit details
- Links to benefit summaries



Humana®

For Agent Use Only.
Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.

Humana Individual Specialty

Rate Sheet Links:

Preventive Value

Preventive Plus

Preventive Plus for Veterans

*Bright Plus and Bright Plus for Veterans

Loyalty Plus

*Complete Dental

*Humana Extend

Dental Value C550

Dental Value HI215

Dental Savings Plus

On-Exchange Dental

*Humana Vision PLUS

Humana Vision

*Focus

*Vision Care Plan (VCP)

*Rate sheet updated for new sales effective April 23, 2025.

Individual Specialty plans

main menu

+ Indicates plans that have an enrollment fee

State	Dental									Vision			
	Preventive Value	Preventive Plus & Preventive Plus for Veterans	Bright Plus & Bright Plus for Veterans	Loyalty Plus	Complete Dental	Humana Extend (DVH)	Dental Value (C550 or HI215)	Dental Savings Plus	On-Exchange Dental	Humana Vision PLUS	Humana Vision	Focus	Vision Care Plan (VCP)
AK			✓		✓			✓+					
AL			✓	✓	✓	✓		✓+	✓	✓			
AR		✓		✓	✓	✓		✓+		✓			
AZ	✓		✓	✓	✓	✓		✓+	✓	✓			
CA	✓		✓	✓+	✓	✓			✓	✓			
CO	✓		✓	✓	✓	✓		✓+		✓			
CT	✓		✓		✓	✓		✓+		✓			
DC	✓		✓	✓	✓	✓		✓+				✓+	
DE	✓		✓	✓	✓	✓		✓+				✓+	
FL	✓		✓	✓	✓	✓	✓+	✓+	✓	✓			
GA	✓		✓		✓	✓	✓+	✓+	✓	✓			
HI	✓		✓		✓	✓			✓	✓			
IA		✓+		✓	✓	✓		✓+		✓			
ID	✓		✓	✓	✓	✓		✓+	✓	✓			
IL	✓		✓		✓	✓	✓+	✓+	✓	✓			
IN	✓		✓	✓+	✓	✓		✓+	✓	✓			
KS	✓		✓	✓	✓	✓		✓+		✓			
KY	✓		✓	✓	✓	✓	✓+	✓+		✓			
LA	✓		✓	✓	✓	✓		✓+	✓	✓			
MA								✓+				✓+	
MD	✓		✓	✓+	✓	✓		✓+		✓			
ME		✓+		✓+	✓			✓+		✓			
MI	✓		✓	✓	✓	✓		✓+	✓	✓			
MN	✓		✓	✓	✓	✓		✓+		✓			
MO	✓		✓	✓	✓	✓	✓+	✓+	✓	✓			
MS	✓		✓	✓	✓	✓		✓+	✓	✓			

Payment may include an administrative fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment.

Continued on next page

Individual Specialty plans

main menu

+ Indicates plans that have an enrollment fee

State	Dental									Vision			
	Preventive Value	Preventive Plus & Preventive Plus for Veterans	Bright Plus & Bright Plus for Veterans	Loyalty Plus	Complete Dental	Humana Extend (DVH)	Dental Value (C550 or HI215)	Dental Savings Plus	On-Exchange Dental	Humana Vision PLUS	Humana Vision	Focus	Vision Care Plan (VCP)
MT								✓+					
NC	✓		✓	✓	✓	✓		✓+	✓		✓+		
ND		✓+		✓	✓			✓+				✓+	
NE	✓		✓	✓	✓	✓		✓+		✓			
NH	✓		✓	✓	✓			✓+		✓			
NJ		✓+		✓				✓+				✓+	
NM	✓		✓	✓+	✓	✓		✓+		✓			
NV												✓+	
NY	✓		✓		✓	✓		✓+				✓+	
OH	✓		✓		✓	✓	✓+	✓+	✓	✓			
OK	✓		✓	✓	✓	✓		✓+	✓	✓			
OR	✓		✓		✓			✓+					
PA	✓		✓	✓	✓	✓		✓+	✓	✓			
RI								✓+					
SC		✓+		✓				✓+					✓+
SD		✓+		✓+	✓	✓		✓+		✓			
TN	✓		✓	✓	✓	✓	✓+	✓+	✓	✓			
TX	✓		✓	✓	✓	✓	✓+	✓+	✓	✓			
UT	✓		✓	✓	✓	✓			✓	✓			
VA	✓		✓	✓	✓	✓		✓+	✓			✓+	
VT					✓			✓+					
WA					✓								
WI	✓		✓	✓	✓	✓		✓+	✓	✓			
WV		✓+		✓+	✓			✓+		✓			
WY		✓+		✓	✓	✓		✓+		✓			

Payment may include an administrative fee. Association membership and fees may be required on some plans in some states. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment.

Previous page

Plan highlights

Humana Individual Dental plans

Plans vary by state.
See state pages for more detail.[1]

	PPO [2, 3]				
	Preventive Value (off-exchange)	**Preventive Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Loyalty Plus** (off-exchange)	**Complete Dental** (off-exchange)
Generally a good fit for:	Budget-conscious individuals who know the importance of preventive dental care, and appreciate a straightforward plan covering preventive and basic services.	Individuals who know the importance of preventive dental care and want some coverage for unexpected dental needs. A great balance to help maintain healthy teeth and gums.	Individuals who know the importance of preventive dental care and want some coverage for unexpected dental needs. A great balance to help maintain healthy teeth and gums, and a beautiful smile.	Individuals who want immediate coverage even if they haven't had prior dental coverage.	Individuals who want robust coverage. Richest benefits may be available immediately for those who have had eligible prior dental coverage.
Plan highlights:	• No waiting periods • One-time deductible for as long as they have the plan • Coverage for preventive and basic services after deductible	• 100% coverage of two covered preventive cleanings and exams per year • Coverage for services like fillings and extractions after a six-month waiting period	• 100% coverage of two covered preventive cleanings and exams per year • Coverage for services like fillings and extractions after a 90 day waiting period • $100 annual allowance for in-office teeth whitening	• No waiting periods • One-time deductible for as long as they have the plan • Covers preventive, basic and major services • Increasing benefits from years one to three	• Comprehensive coverage (100% preventive, 80% basic services, 50% major services) • Coverage in- and out-of-network • Waiting periods apply to basic and major services and may be waived with evidence of prior dental insurance coverage.

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. In New Mexico: This is a limited policy. This is a dental only policy. In Pennsylvania: You may sometimes see elimination period referred to as waiting period.
2 In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.
3 Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.

→ Dental provider directory

For Agent Use Only.

Humana Individual Dental plans (continued)

Plans vary by state.
See state pages for more detail.[1]

	DHMO	Dental Discount [2]	PPO [3, 4]
	Dental Value (C550 & HI215) (off-exchange)	**Dental Savings Plus** (off-exchange)	**On-Exchange Dental**
Generally a good fit for:	Budget-conscious individuals who want coverage, and want to know their costs upfront.	For individuals who want some savings in dental care, but don't want to invest in dental insurance.	Consumers looking to enroll in a plan offered on the Marketplace thru the Federally Facilitated or State-Based Exchange (varies by state).
Plan highlights:	• No waiting periods • No deductible • No annual maximum • Covers preventive, basic and major services • Member must choose a primary care dentist	• In-network providers offer discounts on covered dental services (ranging from 20-40%) • Special discounts on prescriptions, alternative medicine, vision and hearing • **This is not insurance**	• 100% coverage for most preventive services by visiting an in-network provider • Plans sold on Healthcare.gov or a State-Based Exchange (varies by state) • Low deductibles • In most states, the consumer must be enrolled in a medical on-exchange plan in order to select a dental plan on the exchange.

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. In New Mexico: This is a limited policy. This is a dental only policy. In Pennsylvania: You may sometimes see elimination period referred to as waiting period.
2 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
3 In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.
4 Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.

→ Dental provider directory

For Agent Use Only.

Individual Humana Extend (DVH) plans

Plans vary by state.
See state pages for more detail.[1]

	PPO [2, 3]		
	Humana Extend 1250 (off-exchange)	**Humana Extend 2500** (off-exchange)	**Humana Extend 5000** (off-exchange)
Generally a good fit for:	Individuals who want one plan with comprehensive dental coverage with vision[4] and hearing.	Individuals who want one plan with comprehensive dental coverage with vision[4] and hearing. Also includes coverage for dental implants.	Individuals who want one plan with comprehensive dental coverage with vision[4] and hearing. Higher annual maximum. Also includes coverage for dental implants.
Plan highlights:	• $1,250 annual maximum • Annual allowance for teeth whitening • Comprehensive dental coverage (100% preventive, 60% basic services, 30% major services) • Coverage for vision exams • Coverage for hearing exam and hearing aids	• $2,500 annual maximum • Coverage for implants • Annual allowance for teeth whitening • Comprehensive dental coverage (100% preventive, 80% basic services, 50% major services) • Coverage for vision exams and materials • Coverage for hearing exam and hearing aids	• $5,000 annual maximum • Coverage for implants • Annual allowance for teeth whitening • Comprehensive dental coverage (100% preventive, 80% basic services, 50% year 1 and 60% year 2 for major services) • Coverage for vision exams and materials • Coverage for hearing exam and hearing aids

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.
2 In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.
3 Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.
4 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

→ Dental provider directory → Vision provider directory → Hearing resources

Humana Individual Vision plans

Plans vary by state.
See state pages for more detail.[1, 2]

	PPO		
	Humana Vision **Humana Vision PLUS** (off-exchange)	**Vision Care Plan (VCP)** (off-exchange)	**Focus** (off-exchange)
Plan highlights:	• Comprehensive eye exam once a year • Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical® • Frame allowance every 12 months • Lens or contact lens benefit • Lasik discounts • Enhanced benefits when visiting a PLUS provider for members enrolled on a Humana Vision PLUS plan	• Comprehensive eye exam once a year • Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical® • Frame allowance every 24 months • Lens or contact lens benefit	• Comprehensive eye exam once a year • Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical® • Frame allowance every 24 months • Lens or contact lens benefit • Lasik Discounts

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. In New Mexico: This is a limited policy. This is a vision only policy.
2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

→ Vision provider directory

ALABAMA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

ALABAMA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO					
	Smart Choice – High (on-exchange, 2025)		**Smart Choice – Low** (on-exchange, 2025)		**Smart Choice – Lite** (on-exchange, 2025)	
	Adult	**Pediatric**	**Adult**	**Pediatric**	**Adult**	**Pediatric**
Deductible (ded)	$50 *(per adult)*	$35 *(per child)*	$35 *(per adult)*	$35 *(per child)*	$80 *(per adult)*	$35 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	50% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ **Benefit summary**		→ **Benefit summary**		→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

ALABAMA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

ALABAMA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

ALASKA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

ARIZONA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	Benefit summary → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

ARIZONA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

ARIZONA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40	$40
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	Benefit summary → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

ARIZONA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	Benefit summary → **ENG** → **SPA**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

ARKANSAS

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

ARKANSAS

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

ARKANSAS

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

CALIFORNIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*
Annual maximum (Maximum amount the plan will pay during the calendar year[1])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% no ded	100% after lifetime ded
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered
Enrollment Fee	No	Yes	No	No
	Benefit summary → ENG → SPA **Disclosure matrix** → ENG → SPA	**Benefit summary** → ENG → SPA **Disclosure matrix** → ENG → SPA	**Benefit summary** → ENG → SPA **Disclosure matrix** → ENG → SPA	**Benefit summary** → ENG → SPA **Disclosure matrix** → ENG → SPA

1 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan option

CALIFORNIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO Family Dental PPO (on-exchange, 2025)	
	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$75 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,500 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded
Basic services (includes services, such as fillings)	80% after ded	80% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Enrollment Fee	No	No
	Benefit summary → ENG → SPA **Disclosure matrix** → ENG → SPA	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

CALIFORNIA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	Benefit summary → **ENG** → **SPA** **Disclosure matrix** → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA** **Disclosure matrix** → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA** **Disclosure matrix** → **ENG** → **SPA**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

CALIFORNIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	Benefit Summary → **ENG** → **SPA**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

COLORADO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO[5]				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.
5 The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/Dental ID card and requesting a copy.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

COLORADO

When visiting an in-network provider, members receive the following benefits:	PPO[3] Humana Extend 1250	PPO[3] Humana Extend 2500	PPO[3] Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision[2]**	**Vision[2]**
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.
2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
3 The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/Dental ID card and requesting a copy.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

COLORADO

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS[4]
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.
4 The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/ Dental ID card and requesting a copy.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

CONNECTICUT

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

CONNECTICUT

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

CONNECTICUT

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

DELAWARE

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded (*subsequent years*)	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded (*subsequent years*)	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

DELAWARE

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

DELAWARE

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

DISTRICT OF COLUMBIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no deductible	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

DISTRICT OF COLUMBIA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

DISTRICT OF COLUMBIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

FLORIDA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value HI215** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes	Yes
	Benefit summary → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

FLORIDA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO					
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$55 *(per child)*	$50 *(per adult)*	$55 *(per child)*	$80 *(per adult)*	$55 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ Benefit summary		→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

FLORIDA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	Benefit summary → ENG → SPA	**Benefit summary → ENG → SPA**	**Benefit summary → ENG → SPA**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

FLORIDA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	Benefit summary → **ENG** → **SPA**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

GEORGIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value C550** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	$10 – $35 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

GEORGIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice - High (on-exchange, 2025)		Smart Choice - Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	50% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

GEORGIA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40	$40
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

GEORGIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

HAWAII

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% after lifetime ded
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[2]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[2]	Not covered	Not covered
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 May vary by plan; see benefit summary for more specific coverage details.
2 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

HAWAII

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

HAWAII

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

HAWAII

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

IDAHO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

IDAHO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

IDAHO

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

IDAHO

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

ILLINOIS

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value C550** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

ILLINOIS

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO					
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025) [1]	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$25 *(per adult)*	$25 *(per child)*	$25 *(per adult)*	$25 *(per child)*	$60 *(per adult)*	$25 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	70% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ Benefit summary		→ Benefit summary		→ Benefit summary	

1 This plan is sold in specific counties. See the benefit summary for details.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

ILLINOIS

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

ILLINOIS

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

INDIANA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

INDIANA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

INDIANA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet
Links

Vision plan option →

INDIANA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

IOWA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

IOWA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

IOWA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

KANSAS

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

KANSAS

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% no ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

KANSAS

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

KENTUCKY

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value C550** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded (*subsequent years*)	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded (*subsequent years*)	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

KENTUCKY

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

KENTUCKY

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

LOUISIANA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3]	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

LOUISIANA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO	
	Smart Choice (on-exchange, 2025)	
	Adult	**Pediatric**
Deductible (ded)	$45 *(per adult)*	$45 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 (per adult)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

LOUISIANA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

LOUISIANA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MAINE

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	Yes	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

MAINE

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MARYLAND

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

MARYLAND

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40	$40
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

MARYLAND

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MASSACHUSETTS

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	Dental Discount[1] **Dental Savings Plus** (off-exchange)
Deductible (ded)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Discounted fees with in-network provider
Enrollment Fee	Yes
	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

MASSACHUSETTS

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MICHIGAN

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

MICHIGAN

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO	
	Smart Choice (on-exchange, 2025)	
	Adult	**Pediatric**
Deductible (ded)	$40 *(per adult)*	$40 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

MICHIGAN

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

MICHIGAN

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MINNESOTA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded (*subsequent years*)	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded (*subsequent years*)	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

MINNESOTA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

MINNESOTA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MISSISSIPPI

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

MISSISSIPPI

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$25 *(per adult)*	$25 *(per child)*	$25 *(per adult)*	$25 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

MISSISSIPPI

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

MISSISSIPPI

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MISSOURI

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value HI215** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

MISSOURI

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025) [1]	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$45 *(per adult)*	$45 *(per child)*	$100 *(per adult)*	$45 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 This plan is sold in specific counties. See the benefit summary for details.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

MISSOURI

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

MISSOURI

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

MONTANA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	Dental Discount[1] **Dental Savings Plus** (off-exchange)
Deductible (ded)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Discounted fees with in-network provider
Enrollment Fee	Yes
	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.

2 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEBRASKA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

main menu

NEBRASKA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

NEBRASKA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEVADA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW HAMPSHIRE

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

NEW HAMPSHIRE

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW JERSEY

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount[1]
	Loyalty Plus (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded (*subsequent years*)	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded (*subsequent years*)	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW JERSEY

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW MEXICO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental[4] (off-exchange)	**Loyalty Plus**[4] (off-exchange)	**Bright Plus**[4] (off-exchange)	**Preventive Value**[4] (off-exchange)	**Dental Savings Plus**[4] (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 This is a limited policy. This is a dental only policy.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options →

Individual Humana Extend plans

NEW MEXICO

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**
Annual deductible (ded)	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% no ded	100% no ded
Basic services (includes services, such as fillings)	80% after ded Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded	50% after ded *(1st year)* 60% after ded (*subsequent years*)
Implants	50% after ded $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[1]	**Vision**[1]
Vision exam with dilation	$10 copay	$0 copay
Frames	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	$40 copay	$40 copay
Contact lens	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**
Hearing exams	Not Covered	Not Covered
Hearing aids	Not Covered	Not Covered
Enrollment Fee	No	No
	→ **Benefit summary**	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW MEXICO

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS[4]
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.
4 This is a limited policy. This is a vision only policy.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NEW YORK

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

NEW YORK

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	Not Covered	Not Covered	Not Covered
Hearing aids	Not Covered	Not Covered	Not Covered
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

NEW YORK

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NORTH CAROLINA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

NORTH CAROLINA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO					
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*	$80 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ Benefit summary		→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

NORTH CAROLINA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40	$40
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

NORTH CAROLINA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision
Exam with dilation (as necessary)	$15 copay
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$150 allowance, 20% after balance over $150
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$150 allowance, 15% after balance over $150
• Disposable	$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

NORTH DAKOTA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

NORTH DAKOTA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

OHIO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value HI215** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

OHIO

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO	
	Smart Choice (on-exchange, 2025)	
	Adult	**Pediatric**
Deductible (ded)	$35 *(per adult)*	$35 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

OHIO

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

OHIO

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

OKLAHOMA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

OKLAHOMA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	70% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	70% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	70% after ded *(no waiting period)*	Not covered	70% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

OKLAHOMA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

OKLAHOMA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

OREGON

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

PENNSYLVANIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(30 day elimination period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(30 day elimination period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month elimination period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this elimination period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage. You may sometimes see elimination periods referred to as waiting periods.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

PENNSYLVANIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded	80% after ded	60% after ded	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month elimination period)*[2]	50% after ded *(no elimination period)*[2]	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	Benefit summary → **ENG** → **SPA**		**Benefit summary** → **ENG** → **SPA**	

1 May vary by plan; see benefit summary for more specific coverage details.
2 You may sometimes see elimination periods referred to as waiting periods.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

PENNSYLVANIA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(30 day elimination period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(30 day elimination period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(30 day elimination period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month elimination period)*	50% after ded *(12-month elimination period)*	50% after ded *(1st year) (6-month elimination period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month elimination period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month elimination period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this elimination period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage. You may sometimes see elimination periods referred to as waiting periods.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet
Links

Vision plan option →

PENNSYLVANIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

RHODE ISLAND

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	Dental Discount[1] **Dental Savings Plus** (off-exchange)
Deductible (ded)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Discounted fees with in-network provider
Enrollment Fee	Yes
	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

SOUTH CAROLINA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount[1]
	Loyalty Plus (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1. DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

SOUTH CAROLINA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Vision Care Plan (VCP)
Exam with dilation (as necessary)	$10 copay
Frames	$120 allowance, 20% discount off balance over $120
Lenses	$0 copay
Contact lenses[2] • Elective (conventional and disposable)[3] • Medically necessary (1 pair)[4]	 $115 allowance 100%
Frequency (based on date of service) • Exam • Lenses or contact lenses • Frames	 Once every 12 months Once every 12 months Once every 24 months
Enrollment Fee	Yes
Additional plan discounts: • members receive discounts on lens options including: anti reflective and scratch-resistant coatings. • members also receive a 20 percent discount on a second pair of eyeglasses. This is available for 12 months after the covered eye exam and available through the VCP network providers who sold the initial pair of eyeglasses. • after copay, standard polycarbonate available at no charge for dependents less than 19 years old.	
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).
3 The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members may be eligible to receive a 15 percent discount on in-network professional services. The discount for professional services may be available for 12 months after the covered eye exam.
4 Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

SOUTH DAKOTA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	Yes	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

SOUTH DAKOTA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

SOUTH DAKOTA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

TENNESSEE

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				DHMO	Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Value HI215** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 (idividual +1) $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	Yes	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

TENNESSEE

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO					
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$25 *(per adult)*	$25 *(per child)*	$25 *(per adult)*	$25*(per child)*	$50 *(per adult)*	$25 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded	50% after ded	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ Benefit summary		→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

TENNESSEE

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

TENNESSEE

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

TEXAS

Humana Individual Dental plans

When visiting a contracted provider, members receive the following benefits:	Complete Dental (off-exchange)	Loyalty Plus (off-exchange)	Bright Plus (off-exchange)	Preventive Value (off-exchange)	DHMO: Dental Value HI215 (off-exchange)	Dental Discount[1]: Dental Savings Plus (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	$10 – $15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes	Yes
	Benefit summary → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA	**Benefit summary** → ENG → SPA

The plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non contracted dentist their out of pocket costs may be higher than that charged by contracted dentists.

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

TEXAS

Humana Individual Dental plans

When visiting a contracted provider, members receive the following benefits:	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)		Smart Choice – Lite (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$80 *(per adult)*	$60 *(per child)*	$80 *(per adult)*	$80 *(per child)*	$100 *(per adult)*	$80 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	50% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded	Not covered	50% after ded
Enrollment Fee	No	No	No	No	No	No
	→ Benefit summary		→ Benefit summary		→ Benefit summary	

The plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non contracted dentist their out of pocket costs may be higher than that charged by contracted dentists.

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

TEXAS

When visiting a contracted provider, members receive the following benefits:	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40	$40
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Discounts may be available	Discounts may be available	Discounts may be available
Enrollment Fee	No	No	No
	Benefit summary → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA**	**Benefit summary** → **ENG** → **SPA**

The plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non contracted dentist their out of pocket costs may be higher than that charged by contracted dentists.

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

TEXAS

Humana Individual Vision plan

When visiting a contracted provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$0 copay
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0
• Premium contact lens fit and follow-up	10% off retail
Frames	$250 allowance, 20% after balance over $250
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	Benefit summary → ENG → SPA

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

UTAH

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*
Annual maximum (Maximum amount the plan will pay during the calendar year[1])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% no ded	100% no ded	100% after lifetime ded
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[3]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered
Enrollment Fee	No	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

UTAH

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO Smart Choice (on-exchange, 2025)	
	Adult	Pediatric
Deductible (ded)	$45 *(per adult)*	$45 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	100% after ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)*	Not covered
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	Not covered
Enrollment Fee	No	No
	→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

main menu

UTAH

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

UTAH

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

VERMONT

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO **Complete Dental** (off-exchange)	Dental Discount[1] **Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 (*family*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[2])	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[3]	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(6-month waiting period)*[3]	Discounted fees with in-network provider
Enrollment Fee	No	Yes
	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 May vary by plan; see benefit summary for more specific coverage details.
3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

VIRGINIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

VIRGINIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			
	Smart Choice – High (on-exchange, 2025)		Smart Choice – Low (on-exchange, 2025)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$50 *(per child)*	$50 *(per adult)*	$50 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	70% after ded *(6-month waiting period)*	80% after ded *(no waiting period)*	60% after ded *(6-month waiting period)*	50% after ded *(no waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded *(12-month waiting period)*	50% after ded *(no waiting period)*	Not covered	50% after ded
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

VIRGINIA

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

VIRGINIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Focus
Exam with dilation (as necessary)	$10 copay
Contact lenses exam options[2]	
• Standard contact lens fit and follow-up	$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$100 allowance, 20% off balance over $100
Standard plastic lenses	$25 copay
Lens options	
• UV coating	$15 copay
• Tint (solid and gradient)	$15 copay
• Standard scratch-resistance	$15 copay
• Standard polycarbonate[3]	$40 copay
• Standard anti-reflective coating	$45 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$115 allowance, 15% off balance over $115
• Disposable	$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $40.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

WASHINGTON

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO **Complete Dental** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 *(1st year)* $1,500 *(subsequent years)*
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% no ded
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[2]
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[2]
Enrollment Fee	No
	→ **Benefit summary**

1 May vary by plan; see benefit summary for more specific coverage details.
2 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

WEST VIRGINIA

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	Yes	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

WEST VIRGINIA

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

WISCONSIN

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Bright Plus** (off-exchange)	**Preventive Value** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $50 *(individual)* $100 *(individual +1)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	60% after ded *(90 day waiting period)* Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Not covered	Not covered	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.

1 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.

2 May vary by plan; see benefit summary for more specific coverage details.

3 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Additional dental plan options

WISCONSIN

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO	
	Smart Choice (on-exchange, 2025)	
	Adult	Pediatric
Deductible (ded)	$50 *(per adult)*	$85 *(per child)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,000 *(per adult)*	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[1])	100% after ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded *(6-month waiting period)*	50% after ded *(No waiting period)*
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ **Benefit summary**	

1 May vary by plan; see benefit summary for more specific coverage details.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Individual Humana Extend plans

WISCONSIN

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option

WISCONSIN

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

WYOMING

Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount[1]
	Complete Dental (off-exchange)	**Loyalty Plus** (off-exchange)	**Preventive Plus** (off-exchange)	**Dental Savings Plus** (off-exchange)
Deductible (ded)	*Annual ded:* $50 *(individual)* $150 *(family)*	*One-time ded:* $150 *(individual)* $300 *(individual +1)* $450 *(family)*	*Annual ded:* $50 *(individual)* $150 *(family)*	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year[2])	$1,250 *(1st year)* $1,500 *(subsequent years)*	$1,000 *(1st year)* $1,250 *(2nd year)* $1,500 *(subsequent years)*	$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and X-rays[3])	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded *(6-month waiting period)*[4]	40% after ded *(1st year)* 55% after ded *(2nd year)* 70% after ded *(subsequent years)*	50% after ded *(6-month waiting period)*	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded *(12-month waiting period)*[4]	20% after ded *(1st year)* 30% after ded *(2nd year)* 50% after ded *(subsequent years)*	Discounts may be available	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes	Yes
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 DISCOUNT ONLY – NOT INSURANCE. Discounts are only available at participating providers. The range of discounts will vary based upon participating provider chosen to provide services. Retail prices may vary by location. Humana does not make payment for these services. The member is obligated to pay for all services received and will receive a discount from the participating provider. A list of participating providers is available upon request.
2 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
3 May vary by plan; see benefit summary for more specific coverage details.
4 Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Humana Extend (DVH) plan options

Individual Humana Extend plans

WYOMING

When visiting an in-network provider, members receive the following benefits:	PPO Humana Extend 1250	PPO Humana Extend 2500	PPO Humana Extend 5000
	Dental	**Dental**	**Dental**
Annual deductible (ded)	$75 per person	$75 per person *(Waived for preventive services)*	$75 per person *(Waived for preventive services)*
Annual maximum (Maximum amount the plan will pay during the calendar year)	$1,250 per person	$2,500 per person	$5,000 per person
Preventive services (includes services, such as oral exams, cleanings and X-rays)	100% after ded	100% no ded	100% no ded
Basic services (includes services, such as fillings)	60% after ded *(6-month waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)* Includes $100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded *(90 day waiting period)*[1] Includes $200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
Major services (includes services, such as crowns, root canals, dentures, etc.)	30% after ded *(12-month waiting period)*	50% after ded *(12-month waiting period)*	50% after ded *(1st year) (6-month waiting period)*[1] 60% after ded (*subsequent years*)
Implants	Not covered	50% after ded *(12-month waiting period)* $1,000 annual maximum $2,000 lifetime maximum	50% after ded *(1st year) (6-month waiting period)* 60% after ded (*subsequent years*) $2,000 annual maximum $4,000 lifetime maximum
	Vision[2]	**Vision**[2]	**Vision**[2]
Vision exam with dilation	$0 copay	$10 copay	$0 copay
Frames	Not covered	$100 allowance then member pays 80%	$150 allowance then member pays 80%
Lenses - single vision	Not covered	$25 copay, additional lens options available	$25 copay, additional lens options available
Contact lens fit and follow-up (standard)	Not covered	$40 copay	$40 copay
Contact lens	Not covered	$100 allowance then member pays 85%	$150 allowance then member pays 85%
	Hearing	**Hearing**	**Hearing**
Hearing exams	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year	$0 copay One routine hearing exam per year
Hearing aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids	Up to one hearing aid per ear per year $699 copay per ear for Advanced Aids $999 copay per ear for Premium Aids
Enrollment Fee	No	No	No
	→ **Benefit summary**	→ **Benefit summary**	→ **Benefit summary**

1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

Vision plan option →

WYOMING

Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits: [1]	Humana Vision PLUS
Exam with dilation (as necessary)	$10 copay *or $0 copay when visiting a PLUS provider*
Contact lens exam options[2]	
• Standard contact lens fit and follow-up	$0 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	$200 allowance, 20% after balance over $200 *or $250 allowance, 20% after balance over $250 when visiting a PLUS provider*
Standard plastic lenses	$10 copay
Lens options	
• UV coating	$0 copay
• Tint (solid and gradient)	$0 copay
• Standard scratch-resistance	$0 copay
• Standard polycarbonate[3]	$20 copay
• Standard anti-reflective coating	$25 copay
• Standard progressive (add-on to bifocal)	$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	$200 allowance, 15% after balance over $200
• Disposable	$200 allowance
• Medically necessary (1 pair)	$0 copay
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	No
	→ **Benefit summary**

1 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

2 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.). **Premium contact lens fitting:** all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

3 Standard polycarbonate available at no charge to dependents up to 19 years old. All other members pay a fixed charge of $20.

For additional information, such as benefit frequency, limitations, and exclusions, or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.

Jump to:
→ Rate Sheet Links

APPENDIX I:

Here are some additional agent support documents that you might find helpful as you are selling Humana Individual plans.

You can find marketing materials, such as brochures and flyers, in the Marketing Resource Center (MRC), accessible through Vantage.

A popular marketing piece is the **Customizable Brochure** with sections for you to include your name and contact information. The customizable **Dental Plan Comparison Brochure** can be found by searching for GCHJXECEN in the Agent Resources section in the MRC. The customizable **Humana Vision Plus Brochure** can be found by searching for GCHJNGWEN.

Benefit summaries for Individual plans are linked in the separate state pages of this document. Copies of benefit summaries are also available in the Sales Enablement Library.

Important Billing and Enrollment information:

Applications

Digital sales tool options are the preferred method for secure and prompt new sales application processing. You can also share your Agent Online Application (AOA) link directly to your customers. Your personalized AOA link is available by adding your agent ID number (also referred to as SAN) to the following: **Humana.com/aoadv/7-digit-SAN**. If you require access to paper applications, they can be found in the Sales Enablement Library by searching for the form number found in Appendix III of this document.

ID Cards

Humana will send members an ID card upon enrollment (will arrive 7-14 days via postal mail after the application is processed). Be sure to include the member's email address on the application, and Humana will email them their member ID 72 hours after the application is processed. Members can view and print an ID card on the secure member portal HumanaOneMembers.com**.** In-network vision providers won't require the ID card - they will look up the member's benefits online with name and date of birth.

Cancellation limitation

The free look period is 10 days (may vary by state). If the plan is cancelled within the free look period, the member will be refunded the premium and the enrollment fee (where applicable). Your client will also be responsible for the full cost of any services received during this time period. Many Humana Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. That information is available in the member's evidence of coverage which can be accessed via the secure HumanaOneMembers.com site.

Plan administration

The member may choose one of these dates for their recurring payment: the 5th, 15th or 25th. Drafts for recurring payments may be made 2-3 days in advance of these dates. (Note: Members using paper bills will not select a recurring payment date and the payment date will always be the first of the month.)

For individual DHMO plans (Dental Value - HI215 or C550)

The member must choose a primary care dentist (PCD) as part of the application. If they do not indicate the PCD, they will not be able to use the plan, since this is an HMO plan, and the member must be on the roster of the chosen provider. DHMO plans can only have a first-of-the-month effective date, but can be quoted up to 90 calendar days into the future; however the initial payment must be received no later than the 15th of the month prior to the requested effective date. Applications received the 16th through the end of the month will be effective the first of the subsequent month. (Ex: application received on July 16 can be effective Sept. 1.)

For all other individual dental and vision plans

The member can choose the desired effective date. It can be up to 90 calendar days from the application date or as soon as 5 days after the application is processed. The initial payment date selected must be at least five calendar days before the plan's effective date.

Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.
In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.

APPENDIX II:

Benefit summaries for Veterans:

State	Bright Plus for Veterans	Preventive Plus for Veterans
AL	→ Benefit summary	
AK	→ Benefit summary	
AR		→ Benefit summary
AZ	Benefit summary → ENG → SPA	
CA	Benefit Summary → ENG → SPA Disclosure matrix → ENG → SPA	
CO	→ Benefit summary	
CT	→ Benefit summary	
DC	→ Benefit summary	
DE	→ Benefit summary	
FL	Benefit summary → ENG → SPA	
GA	→ Benefit summary	
HI	→ Benefit summary	
IA		→ Benefit summary
ID	→ Benefit summary	
IL	→ Benefit summary	
IN	→ Benefit summary	
KS	→ Benefit summary	
KY	→ Benefit summary	
LA	→ Benefit summary	
MA		
MD	→ Benefit summary	
ME		→ Benefit summary
MI	→ Benefit summary	

State	Bright Plus for Veterans	Preventive Plus for Veterans
MN	→ Benefit summary	
MO	→ Benefit summary	
MS	→ Benefit summary	
NC	→ Benefit summary	
ND		→ Benefit summary
NE	→ Benefit summary	
NH	→ Benefit summary	
NJ		→ Benefit summary
NM	→ Benefit summary	
NY	→ Benefit summary	
OH	→ Benefit summary	
OK	→ Benefit summary	
OR	→ Benefit summary	
PA	→ Benefit summary	
SC		→ Benefit summary
SD		→ Benefit summary
TN	→ Benefit summary	
TX	Benefit summary → ENG → SPA	
UT	→ Benefit summary	
VA	→ Benefit summary	
WI	→ Benefit summary	
WV		→ Benefit summary
WY		→ Benefit summary

APPENDIX III: Paper Application Information

Using electronic applications helps avoid errors and allows for secure and prompt processing. Paper applications should only be used when electronic applications are not available or feasible. When a paper application is needed, it can be found in the Sales Enablement Library, searching by state and the document ID number provided in the chart.

All paper applications for Individual plans include:

- Application Form (document ID provided in chart below)
- Payment Form (document ID: 72030) (state specific payment form required for Maryland)
- Submission Guide Checklist (document ID: GCA0CS2HH)

State	Preventive Value	Loyalty Plus Preventive Plus & Preventive Plus for Veterans Dental Value DHMO (see plan availability by state on pgs. 5 & 6)	Bright Plus & Bright Plus for Veterans	Complete Dental Humana Extend (DVH) (see plan availability by state on pgs. 5 & 6)	Dental Savings Plus (Discount Only - Not Insurance)	Vision (if also purchasing dental see the dental info to choose the correct application)
AK	n/a	n/a	72029 (dental)	72027 (dental)	71120	n/a
AL	n/a	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
AR	n/a	72024 (dental)	n/a	72027 (dental+vision) (DVH)	71120	72027
AZ	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
CA	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	n/a	72024
CO	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
CT	72024 (dental+vision)	n/a	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
DC	72029 (dental)	72024 (dental+vision)	72029 (dental)	72027 (dental) (DVH)	71120	72024
DE	72029 (dental)	72024 (dental+vision)	72029 (dental)	72027 (dental) (DVH)	71120	72024
FL	72024 (dental+vision)	DHMO = 72023 (dental) All others = 72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
GA	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
HI	72024 (dental+vision)	n/a	72024 (dental+vision)	72027 (dental+vision) (DVH)	n/a	72024
IA	n/a	72024 (dental+vision)	n/a	72027 (dental+vision) (DVH)	71120	72024
ID	72029 (dental+vision)	72002 (dental)	72029 (dental+vision)	72027 (dental+vision) (DVH)	71120	72029
IL	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
IN	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
KS	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
KY	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
LA	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
MA	n/a	n/a	n/a	n/a	71120	72024

Continued on next page

State	Preventive Value	Loyalty Plus Preventive Plus & Preventive Plus for Veterans Dental Value DHMO (see plan availability by state on pgs. 5 & 6)	Bright Plus & Bright Plus for Veterans	Complete Dental Humana Extend (DVH) (see plan availability by state on pgs. 5 & 6)	Dental Savings Plus (Discount Only - Not Insurance)	Vision (if also purchasing dental see the dental info to choose the correct application)
MD	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
ME	n/a	72002 (dental+vision)	n/a	72027 (dental+vision)	71120	72002
MI	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
MN	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
MO	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
MS	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
MT	n/a	n/a	n/a	n/a	71120	n/a
NC	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
ND	n/a	72024 (dental+vision)	n/a	72027 (dental)	71120	72024
NE	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
NH	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision)	71120	72024
NJ	n/a	72024 (dental+vision)	n/a	n/a	71120	72024
NM	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental) (DVH)	71120	72024
NV	n/a	n/a	n/a	n/a	n/a	72024 (vision only app)
NY	72002 (dental+vision)	n/a	72002 (dental+vision)	72027 (dental) (DVH)	71120	72002
OH	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
OK	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
OR	72029 (dental)	n/a	72029 (dental)	72027 (dental)	71120	n/a
PA	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
RI	n/a	n/a	n/a	n/a	71120	n/a
SC	n/a	72024 (dental+vision)	n/a	n/a	71120	72024
SD	n/a	72024 (dental+vision)	n/a	72027 (dental+vision) (DVH)	71120	72024
TN	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
TX	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
UT	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	n/a	72024
VA	72029 (dental)	72029 (dental)	72029 (dental)	72027 (dental) (DVH)	71120	72024 (vision only app)
VT	n/a	n/a	n/a	72027 (dental)	71120	n/a
WA	n/a	n/a	n/a	72027 (dental)	n/a	n/a
WI	72024 (dental+vision)	72024 (dental+vision)	72024 (dental+vision)	72027 (dental+vision) (DVH)	71120	72024
WV	n/a	72024 (dental+vision)	n/a	72027 (dental+vision)	71120	72024
WY	n/a	72024 (dental)	n/a	72027 (dental+vision) (DVH)	71120	72027

Previous page