

# Humana Individual Specialty

## Agent Plan Grid

- Dental plans
- Dental, Vision, and Hearing (DVH) plans
- Vision plans

*Revised April 2022*

### WHAT'S NEW?

- *Humana Extend (DVH) plans added in 17 states - includes Dental, Vision, and Hearing coverage - some plans have implant coverage*
- *Required Dental Disclosure Matrix added for California*

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# Humana®

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# Humana Individual Specialty



**Click on a state to view:**

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



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# Humana Individual Specialty

## Rate Sheet Links:

[Preventive Value](#)

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[Loyalty Plus](#)

[Complete Dental](#)

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[Smart Choice \(On exchange\)](#)

[Humana Vision](#)

[Focus](#)

[Vision Care Plan \(VCP\)](#)

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.



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## Individual Specialty plans

Many plans no longer require an enrollment fee  
+ indicates plans that have an enrollment fee

State	Off Exchange Dental								Vision			On Exchange Dental
	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	Humana Vision	Focus	Vision Care Plan (VCP)	Smart Choice
AK								✓+				
AL		✓+		✓	✓			✓+	✓+			✓
AR		✓		✓	✓			✓+			✓+	
AZ	✓		✓	✓	✓	✓		✓+	✓+			✓
CA	✓		✓	✓+	✓				✓+			
CO	✓		✓	✓+	✓			✓+			✓+	
CT	✓		✓		✓	✓		✓+	✓+			
DC	✓		✓	✓	✓	✓		✓+		✓+		
DE	✓		✓	✓	✓			✓+		✓+		
FL	✓		✓	✓	✓	✓	✓+	✓+	✓+			✓
GA	✓		✓		✓	✓	✓+	✓+			✓+	✓
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.

# Individual Specialty plans

Many plans no longer require an enrollment fee  
+ indicates plans that have an enrollment fee

State	Off Exchange Dental								Vision			On Exchange Dental
	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	Humana Vision	Focus	Vision Care Plan (VCP)	Smart Choice
MT								✓+				
NC	✓		✓	✓	✓			✓+	✓+			
ND		✓+		✓	✓			✓+		✓+		
NE	✓		✓	✓+	✓	✓		✓+	✓+			
NH		✓+		✓	✓			✓+				
NJ		✓+		✓				✓+		✓+		
NM	✓		✓	✓+				✓+	✓+			
NV										✓+		
NY	✓		✓		✓			✓+		✓+		
OH	✓		✓		✓		✓+	✓+	✓+			✓
OK	✓		✓	✓	✓	✓		✓+	✓+			
OR								✓+				
PA	✓		✓	✓	✓	✓		✓+	✓+			
RI								✓+				
SC		✓+		✓				✓+			✓+	
SD		✓+		✓+				✓+		✓+		
TN		✓+		✓+	✓		✓+	✓+	✓+			✓
TX	✓		✓	✓	✓	✓	✓+	✓+	✓+			✓
UT	✓		✓	✓	✓	✓				✓+		✓
VA		✓		✓				✓+		✓+		
VT								✓+				
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.

## PLAN HIGHLIGHTS

# Humana Individual Dental plans

Plans vary by state.  
See state pages for more detail.<sup>1</sup>

PPO <sup>2, 3</sup>					
	Preventive Value (off exchange)	Preventive Plus (off exchange)	Bright Plus (off exchange)	Loyalty Plus (off exchange)	Complete Dental (off exchange)
<b>Generally a good fit for:</b>	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 available immediately for those who have had eligible prior dental coverage.
<b>Plan highlights:</b>	<ul style="list-style-type: none"> <li>• No waiting periods</li> <li>• No enrollment fee</li> <li>• One time lifetime deductible</li> <li>• Coverage for preventive and basic services after deductible</li> </ul>	<ul style="list-style-type: none"> <li>• 100% coverage of two covered preventive cleanings and exams per year</li> <li>• Coverage for services like fillings and extractions after a six-month waiting period</li> </ul>	<ul style="list-style-type: none"> <li>• 100% coverage of two covered preventive cleanings and exams per year</li> <li>• Coverage for services like fillings and extractions after a 90 day waiting period</li> <li>• \$100 annual allowance for in-office teeth whitening</li> </ul>	<ul style="list-style-type: none"> <li>• One-time deductible for as long as they have the plan</li> <li>• Covers preventive, basic and major services</li> <li>• Increasing benefits from years one to three</li> <li>• No waiting periods</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive coverage (100% preventive, 80% basic services, 50% major services)</li> <li>• Same coverage in- and out- of network</li> <li>• A PPO plan, with the flexibility of a broad nationwide PPO network</li> </ul>

<sup>1</sup> Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.

<sup>2</sup> 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. You may sometime see this referenced with the terms of in and out of network.

<sup>3</sup> Dental PPO plans are not offered in all states.

→ [Dental provider directory](#)

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[Additional dental plan highlights](#)

## PLAN HIGHLIGHTS



# Humana Individual Dental plans (continued)

Plans vary by state.  
See state pages for more detail.<sup>1</sup>

	DHMO	Dental Discount <sup>2</sup>	PPO <sup>3</sup>
	Dental Value (C550 & HI215) (off exchange)	Dental Savings Plus (off exchange)	Smart Choice (on exchange)
<b>Generally a good fit for:</b>	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 with an on-exchange medical plan preferring to have dental on-exchange as well.
<b>Plan highlights:</b>	<ul style="list-style-type: none"> <li>• No waiting periods</li> <li>• No deductible</li> <li>• No annual maximum</li> <li>• Covers Preventive, Basic and Major services</li> <li>• Member must choose a Primary Care dentist</li> </ul>	<ul style="list-style-type: none"> <li>• In-network providers offer discounts on covered dental services (ranging from 20-40%)</li> <li>• Special discounts on prescriptions, alternative medicine, vision, hearing and clinic care</li> <li>• <b>This is not insurance</b></li> </ul>	<ul style="list-style-type: none"> <li>• 100% coverage for most preventive services by visiting an in-network provider</li> <li>• Plans sold on healthcare.gov</li> <li>• Low deductibles</li> <li>• Member must also have an on-exchange medical plan</li> </ul>

<sup>1</sup> Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.

<sup>2</sup> 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.

<sup>3</sup> Dental PPO plans are not offered in all states.

→ [Dental provider directory](#)

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[Humana Extend \(DVH\) plan highlights](#)

## Individual Humana Extend (DVH) plans

Plans vary by state.  
See state pages for more detail.<sup>1</sup>

	PPO <sup>2, 3</sup>		
	Humana Extend 1250 (off exchange)	Humana Extend 2500 (off exchange)	Humana Extend 5000 (off exchange)
<b>Generally a good fit for:</b>	Individuals who want one plan with comprehensive dental coverage with vision and hearing.	Individuals who want one plan with comprehensive dental coverage with vision and hearing. Also includes coverage for dental implants.	Individuals who want one plan with comprehensive dental coverage with vision and hearing. Higher annual maximum. Also includes coverage for dental implants.
<b>Plan highlights:</b>	<ul style="list-style-type: none"> <li>• \$1,250 annual maximum</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 60% basic services, 30% major services)</li> <li>• Coverage for vision exams</li> <li>• Coverage for hearing exam and hearing aids</li> <li>• No enrollment fee</li> </ul>	<ul style="list-style-type: none"> <li>• \$2,500 annual maximum</li> <li>• Coverage for implants</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 80% basic services, 50% major services)</li> <li>• Coverage for vision exams and materials</li> <li>• Coverage for hearing exam and hearing aids</li> <li>• No enrollment fee</li> </ul>	<ul style="list-style-type: none"> <li>• \$5,000 annual maximum</li> <li>• Coverage for implants</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 80% basic services, 50% year 1 and 60% year 2 for major services)</li> <li>• Coverage for vision exams and materials</li> <li>• Coverage for hearing exam and hearing aids</li> <li>• No enrollment fee</li> </ul>

<sup>1</sup> Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.

<sup>2</sup> 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. You may sometime see this referenced with the terms of in and out of network.

<sup>3</sup> Dental PPO plans are not offered in all states.

→ [Dental provider directory](#)

→ [Vision provider directory](#)

→ [Hearing resources](#)

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# Humana Individual Vision plans

Plans vary by state.  
See state pages for more detail.<sup>1</sup>

	PPO		
	Humana Vision (off exchange)	Vision Care Plan (VCP) (off exchange)	Focus (off exchange)
Plan highlights:	<ul style="list-style-type: none"><li>• Comprehensive eye exam once a year</li><li>• Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision® and Target Optical®</li><li>• Frame allowance every 12 months</li><li>• Lens or contact lens benefit</li><li>• Lasik discounts</li></ul>	<ul style="list-style-type: none"><li>• Comprehensive eye exam once a year</li><li>• Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision® and Target Optical®</li><li>• Frame allowance every 24 months</li><li>• Lens or contact lens benefit</li></ul>	<ul style="list-style-type: none"><li>• Comprehensive eye exam once a year</li><li>• Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision® and Target Optical®</li><li>• Frame allowance every 24 months</li><li>• Lens or contact lens benefit</li><li>• Lasik Discounts</li></ul>

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.

→ [Vision provider directory](#)



# Humana Individual Dental plans

	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:				
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	Yes	Yes
	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>

- 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 Policy-holders 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 Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO					
	Smart Choice – High (on exchange, 2022)		Smart Choice – Low (on exchange, 2022)		Smart Choice – Lite (on exchange, 2022)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$50 (per adult)	\$35 (per child)	\$35 (per adult)	\$35 (per child)	\$80 (per adult)	\$35 (per child)
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
<b>Basic services</b> (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
<b>Major services</b> (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 (no waiting period)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No	No	No	No	No
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>	

<sup>1</sup> 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.

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# Humana Individual Vision plan

	PPO
When visiting an in-network provider, members receive the following benefits:	<b>Humana Vision</b> (off exchange)
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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:

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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 Individual Dental plans

	PPO				Dental Discount <sup>1</sup>
	Smart Choice – High (on exchange, 2022)		Smart Choice – Low (on exchange, 2022)		Dental Savings Plus (off exchange)
	Adult	Pediatric	Adult	Pediatric	
<b>Deductible</b> (ded)	\$50 (per adult)	\$50 (per child)	\$50 (per adult)	\$50 (per child)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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)	Discounted fees with in-network provider
<b>Major services</b> (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	Discounted fees with in-network provider
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>

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 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.

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## Individual Humana Extend plans

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
When visiting an in-network provider, members receive the following benefits:			
	<b>Dental</b>	<b>Dental</b>	<b>Dental</b>
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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
	<b>Vision</b>	<b>Vision</b>	<b>Vision</b>
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40	\$40
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	<b>Hearing</b>	<b>Hearing</b>	<b>Hearing</b>
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	Discounts may be available	Discounts may be available	Discounts may be available
<b>Enrollment Fee</b>	No	No	No
	→ <b>Benefit Summary</b>	→ <b>Benefit Summary</b>	→ <b>Benefit Summary</b>

1 Policy-holders 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.

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.

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# Humana Individual Vision plan

	PPO
When visiting an in-network provider, members receive the following benefits:	<b>Humana Vision</b> (off exchange)
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

- 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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Vision Care Plan (VCP)	
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Frames</b>	\$120 allowance, 20% discount off balance over \$120
<b>Lenses</b>	\$0 copay
<b>Contact lenses</b> <sup>1</sup> <ul style="list-style-type: none"> <li>• Elective (Conventional and disposable)<sup>2</sup></li> <li>• Medically necessary (1 pair)<sup>3</sup></li> </ul>	<div>\$115 allowance</div> <div>100%</div>
<b>Frequency</b> (based on date of service) <ul style="list-style-type: none"> <li>• Exam</li> <li>• Lenses or contact lenses</li> <li>• Frames</li> </ul>	<div>Once every 12 months</div> <div>Once every 12 months</div> <div>Once every 24 months</div>
<b>Enrollment Fee</b>	Yes
<b>Additional plan discounts:</b> <ul style="list-style-type: none"> <li>• members receive discounts on lens options including: anti reflective and scratch-resistant coatings.</li> <li>• 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.</li> <li>• after copay, standard polycarbonate available at no charge for dependents less than 19 years old.</li> </ul>	
→ <b>Benefit summary</b>	

- 1 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).
- 2 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.
- 3 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.

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# Humana Individual Dental plans

	PPO			
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)
When visiting an in-network provider, members receive the following benefits:				
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	Yes	No	No
	→ <a href="#">Benefit summary</a> → <a href="#">Disclosure matrix</a>	→ <a href="#">Benefit summary</a> → <a href="#">Disclosure matrix</a>	→ <a href="#">Benefit summary</a> → <a href="#">Disclosure matrix</a>	→ <a href="#">Benefit summary</a> → <a href="#">Disclosure matrix</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Humana Vision	
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO <sup>5</sup>				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:					
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Vision Care Plan (VCP) <sup>4</sup>
<b>Exam with dilation</b> (as necessary)	\$5 copay
<b>Frames</b>	\$200 allowance, 20% discount off balance over \$200
<b>Lenses</b>	\$0 copay (standard lenses)
<b>Contact lenses<sup>1</sup></b>	
• Elective (Conventional and disposable) <sup>2</sup>	\$200 allowance (for conventional, 15% discount off balance over \$200)
• Medically necessary (1 pair) <sup>3</sup>	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
<b>Additional plan discounts:</b>	
<ul style="list-style-type: none"> <li>members receive discounts on lens options including: anti reflective and scratch-resistant coatings.</li> <li>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.</li> <li>after copay, standard polycarbonate available at no charge for dependents less than 19 years old.</li> </ul>	
	→ <a href="#">Benefit summary</a>

1 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).

2 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.

3 Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	Not covered	Not covered	Discounted fees with in-network provider
<b>Enrollment Fee</b>	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no deductible	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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[Humana Extend \(DVH\) plan options](#)

## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	DHMO	Dental Discount <sup>1</sup>
	Dental Value HI215 (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	No ded	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	\$10 – \$15 copay	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Enrollment Fee</b>	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			
	Smart Choice - High (on exchange, 2022)		Smart Choice - Low (on exchange, 2022)	
	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$50 (per adult)	\$55 (per child)	\$50 (per adult)	\$55 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% no ded	100% after ded
<b>Basic services</b> (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)
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	No	No	No
	→ <a href="#">Benefit summary</a>		→ <a href="#">Benefit summary</a>	

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.

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## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO			DHMO
	Complete Dental (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Value C550 (off exchange)
When visiting an in-network provider, members receive the following benefits:				
<b>Deductible</b> (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
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$35 copay
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>2</sup>	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.
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>2</sup>	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
<b>Enrollment Fee</b>	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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

2 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$50 (per adult)	\$50 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% after ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>1</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

- 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.

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# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40	\$40
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	Discounts may be available	Discounts may be available	Discounts may be available
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

1 Policy-holders 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.

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Vision Care Plan (VCP)	
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Frames</b>	\$120 allowance, 20% discount off balance of \$120
<b>Lenses</b>	\$0 copay
<b>Contact lenses<sup>1</sup></b> <ul style="list-style-type: none"> <li>• Elective (Conventional and disposable)<sup>2</sup></li> <li>• Medically necessary (1 pair)<sup>3</sup></li> </ul>	\$115 allowance 100%
<b>Frequency</b> (based on date of service) <ul style="list-style-type: none"> <li>• Exam</li> <li>• Lenses or contact lenses</li> <li>• Frames</li> </ul>	Once every 12 months Once every 12 months Once every 24 months
<b>Enrollment Fee</b>	Yes
<b>Additional plan discounts:</b> <ul style="list-style-type: none"> <li>• members receive discounts on lens options including: anti reflective and scratch-resistant coatings.</li> <li>• 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.</li> <li>• after copay, standard polycarbonate available at no charge for dependents less than 19 years old.</li> </ul>	
	→ <b>Benefit summary</b>

- 1 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).
- 2 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.
- 3 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		
	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)
<b>Deductible</b> (ded)	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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,250	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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.

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.

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## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			DHMO
	Complete Dental (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Value C550 (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$15 copay
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>2</sup>	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.
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>2</sup>	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
<b>Enrollment Fee</b>	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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

2 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			
	Smart Choice – High (on exchange, 2022)		Smart Choice – Low (on exchange, 2022)	
	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$25 (per adult)	\$25 (per child)	\$25 (per adult)	\$25 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% no ded	100% after ded
<b>Basic services</b> (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)
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>	

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice – Lite (on exchange, 2022) <sup>1</sup>	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$60 (per adult)	\$25 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% after ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	Not covered	50% after ded
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>2</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

<sup>1</sup> This plan is sold in specific counties. See the benefit summary for details.

<sup>2</sup> 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.

<sup>3</sup> 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.

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# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:					
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	Yes	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit summary</a>

- 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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

- 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 Policy-holders 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.

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[Humana Extend \(DVH\) plan options](#)

# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% no ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)
<b>Deductible</b> (ded)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	50% after ded (6-month waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Discounts may be available
<b>Enrollment Fee</b>	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

	DHMO	Dental Discount <sup>1</sup>
When visiting an in-network provider, members receive the following benefits:	<b>Dental Value C550</b> (off exchange)	<b>Dental Savings Plus</b> (off exchange)
<b>Deductible</b> (ded)	No ded	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	\$10 – \$15 copay	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Enrollment Fee</b>	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

- 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)
<b>Deductible</b> (ded)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	50% after ded (6-month waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Discounts may be available
<b>Enrollment Fee</b>	No	No	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$45 (per adult)	\$45 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>1</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

- 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:				
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Vision Care Plan (VCP)	
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Frames</b>	\$120 allowance, 20% off balance over \$120
<b>Lenses</b>	\$0 copay
<b>Contact lenses<sup>1</sup></b> <ul style="list-style-type: none"> <li>• Elective (Conventional and disposable)<sup>2</sup></li> <li>• Medically necessary (1 pair)<sup>3</sup></li> </ul>	\$115 allowance 100%
<b>Frequency</b> (based on date of service) <ul style="list-style-type: none"> <li>• Exam</li> <li>• Lenses or contact lenses</li> <li>• Frames</li> </ul>	Once every 12 months Once every 12 months Once every 24 months
<b>Enrollment Fee</b>	Yes
<b>Additional plan discounts:</b> <ul style="list-style-type: none"> <li>• members receive discounts on lens options including: anti reflective and scratch-resistant coatings.</li> <li>• 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.</li> <li>• after copay, standard polycarbonate available at no charge for dependents less than 19 years old.</li> </ul>	
	→ <b><u>Benefit summary</u></b>

1 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).

2 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.

3 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,250	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	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
<b>Enrollment Fee</b>	No	No	No	Yes
	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$40 (per adult)	\$40 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

<sup>1</sup> 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.

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## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

1 **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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:					
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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[Humana Extend \(DVH\) plan options](#)

## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$25 (per adult)	\$25 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% after ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>1</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

- 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Humana Vision	
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes

→ [Benefit summary](#)

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

## 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<sup>2</sup>)

\$10 – \$15 copay

## Basic services

(includes services, such as fillings)

Benefit available.  
Refer to the plan summary linked below for details.

## Major services

(includes services, such as crowns, root canals, dentures, etc.)

Benefit available. Refer to the plan summary linked below for details.

## Enrollment Fee

Yes

→ [Benefit summary](#)

## Dental Discount<sup>1</sup>

### Dental Savings Plus

(off exchange)

No ded

No annual maximum

Discounts for dental services at 20-40%

Discounted fees with in-network provider

Discounted fees with in-network provider

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			
	Smart Choice - Low (on exchange, 2022)		Smart Choice - Lite (on exchange, 2022) <sup>1</sup>	
	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$45 (per adult)	\$45 (per child)	\$100 (per adult)	\$45 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% after ded	100% after ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)	Not covered	50% after ded
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No	No	No
	→ <a href="#">Benefit summary</a>		→ <a href="#">Benefit summary</a>	

<sup>1</sup> This plan is sold in specific counties. See the benefit summary for details.

<sup>2</sup> 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.

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## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Humana Vision	
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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.

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# Humana Individual Dental plans

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:					
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

- 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 Policy-holders 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.

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[Humana Extend \(DVH\) plan options](#)

## Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

- 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 Policy-holders 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.

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# Humana Individual Dental plans

	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:			
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	Yes	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,250	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	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
<b>Enrollment Fee</b>	Yes	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	Not covered	Not covered	Discounted fees with in-network provider
<b>Enrollment Fee</b>	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

- 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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
When visiting an in-network provider, members receive the following benefits:					
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO			Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <a href="#">Benefit summary</a>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			DHMO
	Complete Dental (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Value HI215 (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$15 copay
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>2</sup>	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.
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>2</sup>	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
<b>Enrollment Fee</b>	No	No	No	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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

2 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$35 (per adult)	\$35 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>1</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

- 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

## Exam with dilation (as necessary)

\$15 copay

## Contact lens exam options<sup>1</sup>

- Standard contact lens fit and follow-up
- Premium contact lens fit and follow-up

\$40 copay

10% off retail

## Frames

\$150 allowance, 20% after balance over \$150

## Standard plastic lenses

\$25 copay

## Lens options

- UV coating
- Tint (solid and gradient)
- Standard scratch-resistance
- Standard polycarbonate<sup>2</sup>
- Standard anti-reflective coating
- Standard progressive (add-on to bifocal)
- Other add-ons and services

\$15 copay

\$15 copay

\$15 copay

\$40 copay

\$45 copay

\$65 copay

20% off retail price

## Contact lenses

- Conventional
- Disposable
- Medically necessary (1 pair)

\$150 allowance, 15% after balance over \$150

\$150 allowance

100%

## Frequency (based on date of service)

- Exam
- Lenses or contact lenses
- Frames

Once every 12 months

Once every 12 months

Once every 12 months

## Enrollment Fee

Yes

→ [Benefit summary](#)

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO				Dental Discount <sup>1</sup>
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Bright Plus (off exchange)	Preventive Value (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>4</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>4</sup>	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
<b>Enrollment Fee</b>	No	No	No	No	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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[Humana Extend \(DVH\) plan options](#)

# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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.

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (30 day waiting period) <sup>3</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (30 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

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

- 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.

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# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (includes services, such as fillings)	60% after ded (30 day waiting period) Includes \$100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded (30 day waiting period) Includes \$100 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)	80% after ded (30 day waiting period) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Vision Care Plan (VCP)	
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Frames</b>	\$120 allowance, 20% discount off balance over \$120
<b>Lenses</b>	\$0 copay
<b>Contact lenses<sup>1</sup></b>	
• Elective (Conventional and disposable) <sup>2</sup>	\$115 allowance
• Medically necessary (1 pair) <sup>3</sup>	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	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 If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).
- 2 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.
- 3 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	Yes	Yes	Yes
	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			DHMO
	Complete Dental (off exchange)	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Value HI215 (off exchange)
<b>Deductible</b> (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
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	\$10 – \$15 copay
<b>Basic services</b> (includes services, such as fillings)	80% after ded	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	50% after ded	Benefit available. Refer to the plan summary linked below for details.
<b>Major services</b> (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)	Discounts may be available	Benefit available. Refer to the plan summary linked below for details.
<b>Enrollment Fee</b>	No	Yes	Yes	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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.

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO			
	Smart Choice – High (on exchange, 2022)		Smart Choice – Low (on exchange, 2022)	
	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$25 (per adult)	\$25 (per child)	\$25 (per adult)	\$25 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% no ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	70% after ded (6-month waiting period)	80% after ded	60% after ded	50% after ded
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	40% after ded (12-month waiting period)	50% after ded	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>	

<sup>1</sup> 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO		Dental Discount <sup>2</sup>
	Smart Choice – Lite (on exchange, 2022) <sup>1</sup>		Dental Savings Plus (off exchange)
	Adult	Pediatric	
<b>Deductible</b> (ded)	\$50 (per adult)	\$25 (per child)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% after ded	100% after ded	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	Not covered	50% after ded	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Discounted fees with in-network provider
<b>Enrollment Fee</b>	No	No	Yes
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>

1 This plan is sold in specific counties. See the benefit summary for details.

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 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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

Humana Vision	
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes

→ **Benefit summary**

- Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting a contracted provider, members receive the following benefits:

	<b>Complete Dental</b> (off exchange)	<b>Loyalty Plus</b> (off exchange)	<b>Bright Plus</b> (off exchange)	<b>Preventive Value</b> (off exchange)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) <b>Includes a Teeth Whitening Allowance</b>	50% after lifetime ded
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting a contracted provider, members receive the following benefits:

	DHMO	Dental Discount <sup>1</sup>
	<b>Dental Value HI215</b> (off exchange)	<b>Dental Savings Plus</b> (off exchange)
<b>Deductible</b> (ded)	No ded	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	No annual maximum	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	\$10 – \$15 copay	Discounts for dental services at 20-40%
<b>Basic services</b> (includes services, such as fillings)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
<b>Enrollment Fee</b>	Yes	Yes
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

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# Humana Individual Dental plans

When visiting a contracted provider, members receive the following benefits:

	Smart Choice – High (on exchange, 2022)		Smart Choice – Low (on exchange, 2022)		Smart Choice – Lite (on exchange, 2022)	
	Adult	Pediatric	Adult	Pediatric	Adult	Pediatric
<b>Deductible</b> (ded)	\$80 (per adult)	\$60 (per child)	\$80 (per adult)	\$80 (per child)	\$100 (per adult)	\$80 (per child)
<b>Annual maximum</b> (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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>1</sup> )	100% no ded	100% no ded	100% no ded	100% after ded	100% after ded	100% after ded
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	No	No	No	No	No
	<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>		<a href="#">→ Benefit summary</a>	

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.

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# Individual Humana Extend plans

When visiting a contracted provider, members receive the following benefits:

	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40	\$40
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	Discounts may be available	Discounts may be available	Discounts may be available
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

1 Policy-holders 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.

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.

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# Humana Individual Vision plan

When visiting a contracted provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- Standard polycarbonate available at no charge to dependents 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 benefits covered when a member visits a non-contracted provider, view the benefit summary linked above or contact your Humana sales representative.

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$45 (per adult)	\$45 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	60% after ded (6-month waiting period)	Not covered
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No
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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.

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# Individual Humana Extend plans

UTAH

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

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

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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	No	Yes
	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>	→ <b>Benefit summary</b>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	Yes	Yes	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

- 1 **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.)
- 2 Standard polycarbonate available at no charge to dependents 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.

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# 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)
<b>Deductible</b> (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)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>1</sup> )	\$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
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% no ded	100% no ded	100% no ded	100% after lifetime ded
<b>Basic services</b> (includes services, such as fillings)	80% after ded (6-month waiting period) <sup>3</sup>	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
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) <sup>3</sup>	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
<b>Enrollment Fee</b>	No	No	No	No
	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>	<a href="#">→ Benefit summary</a>

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 Policy-holders 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:

	PPO	
	Smart Choice (on exchange, 2022)	
	Adult	Pediatric
<b>Deductible</b> (ded)	\$50 (per adult)	\$85 (per child)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>2</sup> )	100% after ded	100% after ded
<b>Basic services</b> (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
<b>Major services</b> (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
<b>Enrollment Fee</b>	No	No
	<a href="#">→ Benefit summary</a>	

## Dental Discount<sup>1</sup>

### Dental Savings Plus (off exchange)

No ded
No annual maximum
Discounts for dental services at 20-40%
Discounted fees with in-network provider
Discounted fees with in-network provider
Yes
<a href="#">→ Benefit summary</a>

- 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.

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# Individual Humana Extend plans

When visiting an in-network provider, members receive the following benefits:

	PPO		
	Humana Extend 1250	Humana Extend 2500	Humana Extend 5000
	Dental	Dental	Dental
<b>Annual deductible</b> (ded)	\$75 per person	\$75 per person (Waived for preventive services)	\$75 per person (Waived for preventive services)
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year)	\$1,250 per person	\$2,500 per person	\$5,000 per person
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays)	100% after ded	100% no ded	100% no ded
<b>Basic services</b> (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) <sup>1</sup> Includes \$200 Teeth Whitening Allowance (per calendar year, does not apply to ded or annual max)
<b>Major services</b> (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) <sup>1</sup> 60% after ded (subsequent years)
<b>Implants</b>	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	Vision	Vision
<b>Vision exam with dilation</b>	\$0 copay	\$10 copay	\$0 copay
<b>Frames</b>	Not covered	\$100 allowance then member pays 80%	\$150 allowance then member pays 80%
<b>Lenses – single vision</b>	Not covered	\$25 copay, additional lens options available	\$25 copay, additional lens options available
<b>Contact lens fit and follow-up</b> (standard)	Not covered	\$40 copay	\$40 copay
<b>Contact lens</b>	Not covered	\$100 allowance then member pays 85%	\$150 allowance then member pays 85%
	Hearing	Hearing	Hearing
<b>Hearing exams</b>	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year	\$0 copay One routine hearing exam per year
<b>Hearing aids</b>	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
<b>Enrollment Fee</b>	No	No	No
	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>	→ <a href="#">Benefit Summary</a>

<sup>1</sup> Policy-holders 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.

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.



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Humana Vision
<b>Exam with dilation</b> (as necessary)	\$15 copay
<b>Contact lens exam options<sup>1</sup></b> <ul style="list-style-type: none"> <li>Standard contact lens fit and follow-up</li> <li>Premium contact lens fit and follow-up</li> </ul>	\$40 copay 10% off retail
<b>Frames</b>	\$150 allowance, 20% after balance over \$150
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b> <ul style="list-style-type: none"> <li>UV coating</li> <li>Tint (solid and gradient)</li> <li>Standard scratch-resistance</li> <li>Standard polycarbonate<sup>2</sup></li> <li>Standard anti-reflective coating</li> <li>Standard progressive (add-on to bifocal)</li> <li>Other add-ons and services</li> </ul>	\$15 copay \$15 copay \$15 copay \$40 copay \$45 copay \$65 copay 20% off retail price
<b>Contact lenses</b> <ul style="list-style-type: none"> <li>Conventional</li> <li>Disposable</li> <li>Medically necessary (1 pair)</li> </ul>	\$150 allowance, 15% after balance over \$150 \$150 allowance 100%
<b>Frequency</b> (based on date of service) <ul style="list-style-type: none"> <li>Exam</li> <li>Lenses or contact lenses</li> <li>Frames</li> </ul>	Once every 12 months Once every 12 months Once every 12 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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# Humana Individual Dental plans

When visiting an in-network provider, members receive the following benefits:	PPO		Dental Discount <sup>1</sup>
	Loyalty Plus (off exchange)	Preventive Plus (off exchange)	Dental Savings Plus (off exchange)
<b>Deductible</b> (ded)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
<b>Annual maximum</b> (Maximum amount the plan will pay during the calendar year <sup>2</sup> )	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
<b>Preventive services</b> (includes services, such as oral exams, cleanings and x-rays <sup>3</sup> )	100% no ded	100% no ded	Discounts for dental services at 20-40%
<b>Basic services</b> (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
<b>Major services</b> (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
<b>Enrollment Fee</b>	No	Yes	Yes
	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>	→ <a href="#">Benefit summary</a>

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.

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# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:

	Focus
<b>Exam with dilation</b> (as necessary)	\$10 copay
<b>Contact lenses exam options<sup>1</sup></b>	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
<b>Frames</b>	\$100 allowance, 20% off balance over \$100
<b>Standard plastic lenses</b>	\$25 copay
<b>Lens options</b>	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate <sup>2</sup>	\$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
<b>Contact lenses</b>	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
<b>Frequency</b> (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
<b>Enrollment Fee</b>	Yes
	→ <b>Benefit summary</b>

1 **Standard contact lens fitting:** spherical clear contact lenses in conventional wear and planned replacement (examples include but 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.)

2 Standard polycarbonate available at no charge to dependents 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.

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## 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 Agent Workbench and Vantage.

A popular marketing piece is the **Customizable Brochure (GCHJXECEN\_B)**, featuring all of the individual dental plans.

- The brochure is customizable, so you can feature only the plans in your state.
- It also has sections for you to add your Agent Contact information.

Information regarding agent commissions: [Humana's Producer Partnership Plan](#).

### Important Billing and Enrollment information:

#### For individual PPO\* Dental and PPO Vision plans

##### **Applications**

Applications can be submitted through the online sales tools. If you need to access paper applications, they can be found in the Plan Documents section in the Marketing Resource Center (MRC).

##### **Plan administration**

The member can choose the desired effective date; it can be up to 90 calendar days from the application date. The initial payment date selected must be at least five calendar days before the plan's effective date. 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 - H1215 or C550)

##### **Applications**

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.

##### **Plan administration**

These 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.) 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 Dental Savings Plus (discount plans)

Plan administration (same as PPO plans)

##### **Cancellation limitation - for all individual plans**

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.

##### **ID Cards - for all individual plans**

Humana will send members an ID card upon enrollment (will arrive 7-14 days after the application is processed via postal mail). 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.

#### See state-specific summary of benefits for additional details

\* Dental PPO plans are not offered in all states.

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. You may sometime see this referenced with the terms of in and out of network.

## APPENDIX II:

### Benefit summaries for Veterans:

State	Bright Plus for Veterans	Preventive Plus for Veterans
AL		→ <a href="#">Benefit summary</a>
AR		→ <a href="#">Benefit summary</a>
AZ	→ <a href="#">Benefit summary</a>	
CA	→ <a href="#">Benefit summary</a> → <a href="#">Disclosure matrix</a>	
CO	→ <a href="#">Benefit summary</a>	
CT	→ <a href="#">Benefit summary</a>	
DC	→ <a href="#">Benefit summary</a>	
DE	→ <a href="#">Benefit summary</a>	
FL	→ <a href="#">Benefit summary</a>	
GA	→ <a href="#">Benefit summary</a>	
IA		→ <a href="#">Benefit summary</a>
ID	→ <a href="#">Benefit summary</a>	
IL	→ <a href="#">Benefit summary</a>	
IN	→ <a href="#">Benefit summary</a>	
KS	→ <a href="#">Benefit summary</a>	
KY		→ <a href="#">Benefit summary</a>
LA		→ <a href="#">Benefit summary</a>
MA	→ <a href="#">Benefit summary</a>	
MD	→ <a href="#">Benefit summary</a>	
ME		→ <a href="#">Benefit summary</a>
MI	→ <a href="#">Benefit summary</a>	
MN	→ <a href="#">Benefit summary</a>	

State	Bright Plus for Veterans	Preventive Plus for Veterans
MO	→ <a href="#">Benefit summary</a>	
MS		→ <a href="#">Benefit summary</a>
NC	→ <a href="#">Benefit summary</a>	
ND		→ <a href="#">Benefit summary</a>
NE	→ <a href="#">Benefit summary</a>	
NH		→ <a href="#">Benefit summary</a>
NJ		→ <a href="#">Benefit summary</a>
NM	→ <a href="#">Benefit summary</a>	
NY	→ <a href="#">Benefit summary</a>	
OH	→ <a href="#">Benefit summary</a>	
OK	→ <a href="#">Benefit summary</a>	
PA	→ <a href="#">Benefit summary</a>	
SC		→ <a href="#">Benefit summary</a>
SD		→ <a href="#">Benefit summary</a>
TN		→ <a href="#">Benefit summary</a>
TX	→ <a href="#">Benefit summary</a>	
UT	→ <a href="#">Benefit summary</a>	
VA		→ <a href="#">Benefit summary</a>
WI	→ <a href="#">Benefit summary</a>	
WV		→ <a href="#">Benefit summary</a>
WY		→ <a href="#">Benefit summary</a>

## APPENDIX III: Paper Application Information

Using electronic forms helps avoid errors and allows for quicker processing.

Agents should only use paper applications when electronic applications are not available or feasible.

When a paper application is needed please use the chart below for reference of what application form numbers to use by product.

The paper applications\* can be found in the Marketing Resource Center (MRC).

\*All paper applications for Individual insurance plans include:

- Paper Application Checklist (GCA0CS2HH)
- Generic Payment Form (GN-72030) or a state specific Maryland Payment Form (MD-72030)
- Federal Non-Discrimination / Multi-Language form (GCHK42UEN)

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	n/a	n/a	GN-71120	n/a
AL	n/a	AL-72024 (dental+vision)	n/a	AL-72027 (dental+vision)	GN-71120	AL-72024
AR	n/a	AR-72024 (dental+vision)	n/a	AR-72027 (dental)	GN-71120	AR-72024
AZ	AZ-72024 (dental+vision)	AZ-72024 (dental+vision)	AZ-72024 (dental+vision)	AZ-72027 (dental+vision) (DVH)	GN-71120	AZ-72024
CA	CA-72024 (dental+vision)	CA-72024 (dental+vision)	CA-72024 (dental+vision)	CA-72027 (dental+vision)	n/a	CA-72024
CO	CO-72029 (dental)	CO-72002 (dental+vision)	CO-72029 (dental)	CO-72027 (dental)	GN-71120	CO-72002
CT	CT-72024 (dental+vision)	n/a	CT-72024 (dental+vision)	CT-72027 (dental+vision) (DVH)	GN-71120	CT-72024
DC	DC-72029 (dental)	DC-72024 (dental+vision)	DC-72029 (dental)	DC-72027 (dental) (DVH)	GN-71120	DC-72024
DE	DE-72029 (dental)	DE-72024 (dental+vision)	DE-72029 (dental)	DE-72027 (dental)	GN-71120	DE-72024
FL	FL-72024 (dental+vision)	DHMO = FL-72023 (dental) All others = FL-72024 (dental+vision)	FL-72024 (dental+vision)	FL-72027 (dental+vision) (DVH)	GN-71120	FL-72024
GA	GA-72024 (dental+vision)	GA-72024 (dental+vision)	GA-72024 (dental+vision)	GA-72027 (dental) (DVH)	GN-71120	GA-72024
IA	n/a	IA-72024 (dental+vision)	n/a	IA-72027 (dental+vision)	GN-71120	IA-72024
ID	ID-72029 (dental)	ID-72002 (dental/vision)	ID-72029 (dental)	ID-72027 (DVH)	GN-71120	ID-72002
IL	IL-72024 (dental+vision)	IL-72024 (dental+vision)	IL-72024 (dental+vision)	IL-72027 (dental+vision) (DVH)	GN-71120	IL-72024
IN	IN-72024 (dental+vision)	IN-72024 (dental+vision)	IN-72024 (dental+vision)	IN-72027 (dental+vision)	GN-71120	IN-72024
KS	KS-72024 (dental+vision)	KS-72024 (dental+vision)	KS-72024 (dental+vision)	KS-72027 (dental+vision) (DVH)	GN-71120	KS-72024
KY	n/a	KY-72024 (dental+vision)	n/a	KY-72027 (dental+vision)	GN-71120	KY-72024
LA	n/a	LA-72024 (dental+vision)	n/a	LA-72027 (dental+vision)	GN-71120	LA-72024
MA	MA-72029 (dental)	MA-72024 (dental+vision)	MA-72029 (dental)	n/a	GN-71120	MA-72024

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	MD-72024 (dental)	MD-72024 (dental)	MD-72024 (dental)	MD-72027 (dental)	GN-71120	MD-72002
ME	n/a	ME-72002 (dental+vision)	n/a	ME-72027 (dental)	GN-71120	ME-72002
MI	MI-72024 (dental+vision)	MI-72024 (dental+vision)	MI-72024 (dental+vision)	MI-72027 (dental+vision) (DVH)	GN-71120	MI-72024
MN	MN-72029 (dental)	MN-72002 (dental+vision)	MN-72029 (dental)	MN-72027 (dental) (DVH)	GN-71120	MN-72002
MO	MO-72024 (dental+vision)	MO-72024 (dental+vision)	MO-72024 (dental+vision)	MO-72027 (dental+vision) (DVH)	GN-71120	MO-72024
MS	n/a	MS-72024 (dental+vision)	n/a	MS-72027 (dental+vision)	GN-71120	MS-72024
MT	n/a	n/a	n/a	n/a	GN-71120	n/a
NC	NC-72024 (dental+vision)	NC-72024 (dental+vision)	NC-72024 (dental+vision)	NC-72027 (dental+vision)	GN-71120	NC-72024
ND	n/a	ND-72024 (dental+vision)	n/a	ND-72027 (dental)	GN-71120	ND-72024
NE	NE-72024 (dental+vision)	NE-72024 (dental+vision)	NE-72024 (dental+vision)	NE-72027 (dental+vision) (DVH)	GN-71120	NE-72024
NH	n/a	NH-72024 (dental)	n/a	NH-72027 (dental)	GN-71120	n/a
NJ	n/a	NJ-72024 (dental+vision)	n/a	n/a	GN-71120	NJ-72024
NM	NM-72024 (dental+vision)	NM-72024 (dental+vision)	NM-72024 (dental+vision)	n/a	GN-71120	NM-72024
NV	n/a	n/a	n/a	n/a	n/a	NV-72024 (vision only app)
NY	NY-72002 (dental+vision)	n/a	NY-72002 (dental+vision)	NY-72027 (dental)	GN-71120	NY-72002
OH	OH-72024 (dental+vision)	OH-72024 (dental+vision)	OH-72024 (dental+vision)	OH-72027 (dental)	GN-71120	OH-72024
OK	OK-72024 (dental+vision)	OK-72024 (dental+vision)	OK-72024 (dental+vision)	OK-72027 (dental+vision) (DVH)	GN-71120	OK-72024
OR	n/a	n/a	n/a	n/a	GN-71120	n/a
PA	PA-72024 (dental+vision)	PA-72024 (dental+vision)	PA-72024 (dental+vision)	PA-72027 (dental+vision) (DVH)	GN-71120	PA-72024
RI	n/a	n/a	n/a	n/a	GN-71120	n/a
SC	n/a	SC-72024 (dental+vision)	n/a	n/a	GN-71120	SC-72024
SD	n/a	SD-72024 (dental+vision)	n/a	n/a	GN-71120	SD-72024
TN	n/a	TN-72024 (dental+vision)	n/a	TN-72027 (dental+vision)	GN-71120	TN-72024
TX	TX-72024 (dental+vision)	TX-72024 (dental+vision)	TX-72024 (dental+vision)	TX-72027 (dental+vision) (DVH)	GN-71120	TX-72024
UT	UT-72029 (dental)	UT-72002 (dental+vision)	UT-72029 (dental)	UT-72027 (dental) (DVH)	n/a	UT-72002
VA	n/a	VA-72024 (dental+vision)	n/a	n/a	GN-71120	VA-72024
VT	n/a	n/a	n/a	n/a	GN-71120	n/a
WI	WI-72024 (dental+vision)	WI-72024 (dental+vision)	WI-72024 (dental+vision)	WI-72027 (dental+vision) (DVH)	GN-71120	WI-72024
WV	n/a	WV-72024 (dental+vision)	n/a	n/a	GN-71120	WV-72024
WY	n/a	WY-72024 (dental+vision)	n/a	n/a	GN-71120	WY-72024