

Humana Individual Dental and Vision

Agent Plan Grid

July 1, 2020



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This material, including any subpart(s), is not to be used as marketing and is not to be provided to a prospect, an applicant, member, group, or the general public. For proposed benchmark and ensured accuracy of plan benefit data please refer to the Summary of Benefits.

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GCHK38JEN 0720

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Humana Individual Dental & Vision



Click on a state to view:

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



Humana Individual Dental & Vision

Rate Sheet Links:

[Bright Plus and Bright Plus for Veterans](#)

[Complete Dental](#)

[Loyalty Plus](#)

[Preventive Plus](#)

[Preventive Plus for Veterans](#)

[Preventive Value](#)

[Dental Value \(C550\)](#)

[Dental Value \(HI215\)](#)

[Dental Savings Plus](#)

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

[Humana Vision](#)

[Focus](#)

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

Premiums may include a \$1 administrative fee. Association membership and fees may be required in some states and on some plans.

A \$35 one-time, non-refundable enrollment fee may apply, depending on the product (The fee is non-refundable as allowed by state requirements).



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 Individual Dental & Vision plans

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	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	✓		✓	✓	✓	✓	✓	✓			✓



Individual Dental & Vision plans

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	Dental Value (C550 or HI215)	Dental Savings Plus	Humana Vision	Focus	Vision Care Plan (VCP)	Smart Choice
MS		✓		✓			✓	✓			✓
MT							✓				
NC	✓		✓	✓	✓		✓	✓			
ND		✓		✓			✓		✓		
NE	✓		✓	✓			✓	✓			
NH		✓					✓				
NJ		✓		✓			✓		✓		
NM	✓		✓	✓			✓	✓			
NV									✓		
NY	✓		✓				✓		✓		
OH	✓		✓		✓	✓	✓	✓			✓
OK	✓		✓	✓			✓	✓			
OR							✓				
PA	✓		✓	✓	✓		✓	✓			✓
RI							✓				
SC		✓		✓			✓			✓	
SD		✓		✓			✓		✓		
TN		✓		✓	✓	✓	✓	✓			✓
TX	✓		✓	✓	✓	✓	✓	✓			✓
UT	✓		✓	✓	✓				✓		✓
VA		✓		✓			✓		✓		
VT							✓				
WI	✓		✓	✓	✓		✓	✓			✓
WV		✓		✓			✓	✓			
WY		✓		✓					✓		



Humana Individual Dental plans

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

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

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

² In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists. You may sometime see this referenced with the terms of in and out of network.

→ [Dental provider directory](#)

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Humana Individual Dental plans

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

	DHMO	Dental Discount	PPO
	Dental Value (C550 & HI215) (off exchange)	Dental Savings Plus (off exchange)	Smart Choice (on exchange)
Generally a good fit for:	Budget-conscious individuals who want coverage, and want to know their costs upfront.	For individuals who want some savings in dental care, but don't want to invest in dental insurance.	Consumers with an on-exchange medical plan preferring to have dental on-exchange as well.
Plan highlights:	- No waiting periods - No deductible - No annual maximum - Covers Preventive, Basic and Major services - Member must choose a Primary Care dentist	- In-network providers offer discounts on covered dental services (ranging from 20-40%) - Special discounts on prescriptions, alternative medicine, vision, hearing and clinic care This is not insurance	100% coverage for most preventive services by visiting an in-network provider - Plans sold on healthcare.gov - Low deductibles - Member must also have an on-exchange medical plan

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

→ [Dental provider directory](#)

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Humana Individual Vision plan

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

	PPO		
	Humana Vision (off exchange)	Vision Care Plan (VCP) (off exchange)	Focus (off exchange)
Plan highlights:	• Comprehensive eye exam once a year • Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision®, Target Optical® and JCPenney Optical • Frame allowance every 12 months • Lens or contact lens benefit • Lasik discounts	• Comprehensive eye exam once a year • Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision®, Target Optical® and JCPenney Optical • Frame allowance every 24 months • Lens or contact lens benefit	• Comprehensive eye exam once a year • Large network of more than 35,000 participating optometrist, ophthalmologist and national retail locations, including LensCrafters®, Pearle Vision®, Target Optical® and JCPenney Optical • Frame allowance every 24 months • Lens or contact lens benefit • Lasik Discounts

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

→ [Vision provider directory](#)



Humana Individual Dental plans

ALABAMA

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 are 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 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

ALABAMA

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

	PPO			
	Smart Choice – High (on exchange)		Smart Choice – Low (on exchange)	
	Adult	Pediatric	Adult	Pediatric
Deductible (ded)	\$35 (per adult)	\$35 (per child)	\$35 (per adult)	\$35 (per child)
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ¹)	100% no ded	100% no ded	100% no ded	100% after ded
Basic services (includes services, such as fillings)	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)
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded (12-month waiting period)	50% after ded (no waiting period)	Not covered	50% after ded (no waiting period)
Enrollment Fee	No	No	No	No
	→ Benefit summary		→ Benefit summary	

¹ May vary by plan; see benefit summary for details

[For additional information 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

ALABAMA

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

Exam with dilation (as necessary)

\$15 copay

Contact lens exam options¹

- 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 polycarbonate²
- 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 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

ALASKA

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-rays²)

Discounts for dental services at 20-40%

Basic services

(includes services, such as fillings)

Discounted fees with in-network provider

Major services

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

Discounted fees with in-network provider

Enrollment Fee

Yes

[→ Benefit summary](#)

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

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Humana Individual Dental plans

ARIZONA

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

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

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

ARIZONA

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

	PPO				Dental Discount ¹
	Smart Choice – High (on exchange)		Smart Choice – Low (on exchange)		Dental Savings Plus (off exchange)
	Adult	Pediatric	Adult	Pediatric	
Deductible (ded)	\$50 (per adult)	\$50 (per child)	\$50 (per adult)	\$50 (per child)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% no ded	100% no ded	100% after ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	70% after ded (6-month waiting period)	80% after ded (no waiting period)	60% after ded (6-month waiting period)	50% after ded (no waiting period)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded (12-month waiting period)	50% after ded (no waiting period)	Not covered	50% after ded	Discounted fees with in-network provider
Orthodontia	Not covered	50% after ded	Not covered	50% after ded	Up to a 20% discount
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary		→ Benefit summary		→ Benefit summary

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2 May vary by plan; see benefit summary for details

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[For additional information or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.](#)



Humana Individual Vision plan

ARIZONA

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

Exam with dilation (as necessary)

\$15 copay

Contact lens exam options¹

- 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 polycarbonate²
- 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 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

ARKANSAS

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

ARKANSAS

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

Vision Care Plan (VCP)	
Exam with dilation (as necessary)	\$10 copay
Frames	\$120 allowance, 20% discount off balance over \$120
Lenses	\$25 copay
Contact lenses ¹	
• Elective (Conventional and disposable) ²	\$115 allowance
• Medically necessary (1 pair) ³	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
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 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

CALIFORNIA

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

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

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 are 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 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

CALIFORNIA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary ENG → Benefit summary SP

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 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

COLORADO

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 are 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 your network, is available by calling the customer service number found on your Humana Vision ID Card/Dental ID card and requesting a copy.

For additional information 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

COLORADO

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

Vision Care Plan (VCP) ⁴	
Exam with dilation (as necessary)	\$10 copay
Frames	\$120 allowance, 20% discount off balance over \$120
Lenses	\$25 copay
Contact lenses¹	
• Elective (Conventional and disposable) ²	\$115 allowance
• Medically necessary (1 pair) ³	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
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.
4. The Network Access Plan, which describes an access plan specific to your network, is available by calling the customer service number found on your Humana Vision ID Card/ Dental ID card and requesting a copy.

[For additional information 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

CONNECTICUT

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 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

CONNECTICUT

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

DISTRICT OF COLUMBIA

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

DELAWARE

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 are 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 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

DELAWARE

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

- 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 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

FLORIDA

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

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

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 are 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 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

FLORIDA

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

	PPO		DHMO	Dental Discount ¹
	Smart Choice (on exchange)		Dental Value HI215 (off exchange)	Dental Savings Plus (off exchange)
	Adult	Pediatric		
Deductible (ded)	\$50 (per adult)	\$55 (per child)	No ded	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year ²)	\$1,000 (per adult)	No annual maximum	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ³)	100% no ded	100% after ded	\$10 – \$15 copay	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	60% after ded (6-month waiting period)	50% after ded (No waiting period)	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Benefit available. Refer to the plan summary linked below for details.	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes	Yes
	→ Benefit summary ENG		→ Benefit summary ENG → Benefit summary SP	→ Benefit summary ENG → Benefit summary SP

¹ THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

FLORIDA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary ENG → Benefit summary SP

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 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

GEORGIA

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)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$50 (individual) \$100 (individual +1) \$150 (family)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ¹)	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$35 copay
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period) ²	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) ²	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
Enrollment Fee	Yes	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

2 Policy-holders who provide proof of 12 months prior coverage are 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 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

GEORGIA

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

	PPO	
	Smart Choice (on exchange)	
	Adult	Pediatric
Deductible (ded)	\$50 (per adult)	\$50 (per child)
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% after ded
Basic services (includes services, such as fillings)	60% after ded (6-month waiting period)	50% after ded (No waiting period)
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ Benefit summary	

Dental Discount¹

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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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

For additional information 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

GEORGIA

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

Vision Care Plan (VCP)	
Exam with dilation (as necessary)	\$10 copay
Frames	\$120 allowance, 20% discount off balance of \$120
Lenses	\$25 copay
Contact lenses¹ • Elective (Conventional and disposable)² • Medically necessary (1 pair)³	\$115 allowance 100%
Frequency (based on date of service) • Exam • Lenses or contact lenses • Frames	Once every 12 months Once every 12 months Once every 24 months
Enrollment Fee	Yes

Additional plan discounts:

- members receive discounts on lens options including: anti reflective and scratch-resistant coatings.
- members also receive a 20 percent discount on a second pair of eyeglasses. This is available for 12 months after the covered eye exam and available through the VCP network providers who sold the initial pair of eyeglasses.
- after copay, standard polycarbonate available at no charge for dependents less than 19 years old.

[→ Benefit summary](#)

1. 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 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

IDAHO

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

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

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

[For additional information 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

IDAHO

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

ILLINOIS

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)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$50 (individual) \$100 (individual +1) \$150 (family)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ¹)	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$15 copay
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period) ³	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) ²	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
Enrollment Fee	Yes	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

2 Policy-holders who provide proof of 12 months prior coverage are 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 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

ILLINOIS

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

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

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

[For additional information 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

ILLINOIS

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

	PPO	
	Smart Choice – Lite (on exchange) ¹	
	Adult	Pediatric
Deductible (ded)	\$60 (per adult)	\$25 (per child)
Maximum out-of-pocket	No maximum out-of-pocket	\$350 (1 child) \$700 (2 or more children)
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% after ded	100% after ded
Basic services (includes services, such as fillings)	Not covered	50% after ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ Benefit summary	

Dental Discount ²	
Dental Savings Plus (off exchange)	
No ded	
No maximum out-of-pocket	
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 This plan is sold in specific counties. See the benefit summary for details.

2 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

[For additional information 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

ILLINOIS

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

INDIANA

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 are 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 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

INDIANA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

IOWA

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

IOWA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

KANSAS

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 are 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 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

KANSAS

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

KENTUCKY

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 C550 (off exchange)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year ¹)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% no ded	100% no ded	\$10 – \$15 copay
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period) ³	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	50% after ded (6-month waiting period)	Benefit available. Refer to the plan summary linked below for details.
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) ³	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Discounts may be available	Benefit available. Refer to the plan summary linked below for details.
Enrollment Fee	Yes	Yes	Yes	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

KENTUCKY

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

	PPO				Dental Discount ¹
	Smart Choice – High (on exchange)		Smart Choice – Low (on exchange)		Dental Savings Plus (off exchange)
	Adult	Pediatric	Adult	Pediatric	
Deductible (ded)	\$25 (per adult)	\$25 (per child)	\$50 (per adult)	\$35 (per child)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000	No annual maximum	\$1,000	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% after ded	100% no ded	100% after ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period)	80% after ded (No waiting period)	50% after ded (6-month waiting period)	50% after ded (No waiting period)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Not covered	50% after ded	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary		→ Benefit summary		→ Benefit summary

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

KENTUCKY

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

LOUISIANA

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

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

LOUISIANA

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

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

Dental Discount¹

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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

LOUISIANA

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

Exam with dilation (as necessary)

\$15 copay

Contact lens exam options¹

- 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 polycarbonate²
- 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 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

MAINE

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

	PPO
	Preventive Plus (off exchange)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)
Maximum out-of-pocket	No maximum out-of-pocket
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded
Basic services (includes services, such as fillings)	50% after ded (6-month waiting period)
Major services (includes services, such as crowns, root canals, dentures, etc.)	Discounts may be available
Enrollment Fee	Yes
	→ Benefit summary

Dental Discount¹

Dental Savings Plus (off exchange)
No ded
No maximum out-of-pocket
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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

MAINE

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MARYLAND

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

MARYLAND

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

Vision Care Plan (VCP)	
Exam with dilation (as necessary)	\$10 copay
Frames	\$120 allowance, 20% off balance over \$120
Lenses	\$25 copay
Contact lenses ¹ • Elective (Conventional and disposable)² • Medically necessary (1 pair)³	\$115 allowance 100%
Frequency (based on date of service) • Exam • Lenses or contact lenses • Frames	Once every 12 months Once every 12 months Once every 24 months
Enrollment Fee	Yes

Additional plan discounts:

- members receive discounts on lens options including: anti reflective and scratch-resistant coatings.
- members also receive a 20 percent discount on a second pair of eyeglasses. This is available for 12 months after the covered eye exam and available through the VCP network providers who sold the initial pair of eyeglasses.
- after copay, standard polycarbonate available at no charge for dependents less than 19 years old.

[→ Benefit summary](#)

1. 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 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

MASSACHUSETTS

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 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

MASSACHUSETTS

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MICHIGAN

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 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

MICHIGAN

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

	PPO	
	Smart Choice (on exchange)	
	Adult	Pediatric
Deductible (ded)	\$40 (per adult)	\$40 (per child)
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% after ded
Basic services (includes services, such as fillings)	50% after ded (6-month waiting period)	50% after ded (No waiting period)
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded
Enrollment Fee	No	No
	→ Benefit summary	

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

MICHIGAN

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MINNESOTA

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 are 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 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

MINNESOTA

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MISSISSIPPI

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

- 1 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information 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

MISSISSIPPI

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

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

Dental Discount¹

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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

For additional information 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

MISSISSIPPI

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MISSOURI

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

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

- 1 LOYALTY PLUS: Maximum amount the plan will pay during the plan year.
- 2 May vary by plan; see benefit summary for more specific coverage details.
- 3 Policy-holders who provide proof of 12 months prior coverage are 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 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

MISSOURI

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

MISSOURI

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

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

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

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

[For additional information 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

MISSOURI

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

MONTANA

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)

Discounts for dental services at 20-40%

Basic services

(includes services, such as fillings)

Discounted fees with in-network provider

Major services

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

Discounted fees with in-network provider

Enrollment Fee

Yes

[→ Benefit summary](#)

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

[For additional information 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

NEBRASKA

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 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

NEBRASKA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

NEVADA

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

NEW HAMPSHIRE

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

Deductible (ded)

Annual ded:
\$50 (individual)
\$150 (family)

Annual maximum

(Maximum amount the plan will pay during the calendar year)

\$1,000

Preventive services

(includes services, such as oral exams, cleanings and x-rays²)

100% no ded

Basic services

(includes services, such as fillings)

50% after ded
(6-month waiting period)

Major services

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

Discounts may be available

Enrollment Fee

Yes

[→ Benefit summary](#)

Dental Discount¹

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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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

[For additional information 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

NEW JERSEY

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

NEW JERSEY

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

NEW MEXICO

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
 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 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

NEW MEXICO

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

NEW YORK

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 2 May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

NEW YORK

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

NORTH CAROLINA

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 are 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 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	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

- 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 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

NORTH DAKOTA

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

NORTH DAKOTA

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

OHIO

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)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$50 (individual) \$100 (individual +1) \$150 (family)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,250	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ¹)	100% no ded	100% no ded	100% after lifetime ded	\$10 – \$15 copay
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period) ²	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded	Benefit available. Refer to the plan summary linked below for details.
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) ²	Not covered	Not covered	Benefit available. Refer to the plan summary linked below for details.
Enrollment Fee	Yes	No	No	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

2 Policy-holders who provide proof of 12 months prior coverage are 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 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

OHIO

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

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

Dental Discount¹

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 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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

For additional information 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

OHIO

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

Exam with dilation (as necessary)

\$15 copay

Contact lens exam options¹

- 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 polycarbonate²
- 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 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

OKLAHOMA

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

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

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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 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

OKLAHOMA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

OREGON

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-rays²)

Discounts for dental services at 20-40%

Basic services

(includes services, such as fillings)

Discounted fees with in-network provider

Major services

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

Discounted fees with in-network provider

Enrollment Fee

Yes

[→ Benefit summary](#)

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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

[For additional information 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

PENNSYLVANIA

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

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

PENNSYLVANIA

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

	PPO		Dental Discount ¹
	Smart Choice (on exchange)		Dental Savings Plus (off exchange)
	Adult	Pediatric	
Deductible (ded)	\$40 (per adult)	\$40 (per child)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded (adults)	100% after ded (children)	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	50% after ded (30-day waiting period)	50% after ded (No waiting period)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	Not covered	50% after ded	Discounted fees with in-network provider
Enrollment Fee	No	No	Yes
	→ Benefit summary		→ Benefit summary

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 2 May vary by plan; see benefit summary for more specific coverage details.

For additional information 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

PENNSYLVANIA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

RHODE ISLAND

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-rays²)

Discounts for dental services at 20-40%

Basic services

(includes services, such as fillings)

Discounted fees with in-network provider

Major services

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

Discounted fees with in-network provider

Enrollment Fee

Yes

[→ Benefit summary](#)

1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

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

[For additional information, view the benefit summary linked above or contact your Humana sales representative.](#)

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Humana Individual Dental plans

SOUTH CAROLINA

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

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

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
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 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)	
Exam with dilation (as necessary)	\$10 copay
Frames	\$120 allowance, 20% discount off balance over \$120
Lenses	\$25 copay
Contact lenses ¹	
• Elective (Conventional and disposable) ²	\$115 allowance
• Medically necessary (1 pair) ³	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes

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 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

SOUTH DAKOTA

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

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

Dental Discount¹

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. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
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 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

SOUTH DAKOTA

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

TENNESSEE

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)
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year ¹)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,000	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% no ded	100% no ded	\$10 – \$15 copay
Basic services (includes services, such as fillings)	80% after ded	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	50% after ded	Benefit available. Refer to the plan summary linked below for details.
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Discounts may be available	Benefit available. Refer to the plan summary linked below for details.
Enrollment Fee	Yes	Yes	Yes	Yes
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

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

For additional information 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

TENNESSEE

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

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

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

[For additional information 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

TENNESSEE

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

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

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

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

3 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.

[For additional information 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

TENNESSEE

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

TEXAS

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

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

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

TEXAS

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

	Smart Choice – High (on exchange)		Smart Choice – Low (on exchange)		Dental Discount ¹
	Adult	Pediatric	Adult	Pediatric	Dental Savings Plus (off exchange)
Deductible (ded)	\$80 (per adult)	\$60 (per child)	\$80 (per adult)	\$80 (per child)	No ded
Annual maximum (Maximum amount the plan will pay during the calendar year)	\$1,000 (per adult)	No annual maximum	\$1,000 (per adult)	No annual maximum	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% no ded	100% no ded	100% after ded	Discounts for dental services at 20-40%
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period)	80% after ded (No waiting period)	50% after ded (6-month waiting period)	50% after ded (No waiting period)	Discounted fees with in-network provider
Major services (includes services, such as crowns, root canals, dentures, etc.)	40% after ded (12-month waiting period)	50% after ded (No waiting period)	Not covered	50% after ded	Discounted fees with in-network provider
Enrollment Fee	No	No	No	No	Yes
	→ Benefit summary		→ Benefit summary		→ Benefit summary

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2. May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

TEXAS

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

UTAH

	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:				
Deductible (ded)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$150 (individual) \$300 (individual +1) \$450 (family)	Annual ded: \$50 (individual) \$150 (family)	One-time ded: \$50 (individual) \$100 (individual +1) \$150 (family)
Annual maximum (Maximum amount the plan will pay during the calendar year ¹)	\$1,250 (1st year) \$1,500 (subsequent years)	\$1,000 (1st year) \$1,250 (2nd year) \$1,500 (subsequent years)	\$1,250	No annual maximum
Preventive services (includes services, such as oral exams, cleanings and x-rays ²)	100% no ded	100% no ded	100% no ded	100% after lifetime ded
Basic services (includes services, such as fillings)	80% after ded (6-month waiting period) ³	40% after ded (1st year) 55% after ded (2nd year) 70% after ded (subsequent years)	60% after ded (90 day waiting period) Includes a Teeth Whitening Allowance	50% after lifetime ded
Major services (includes services, such as crowns, root canals, dentures, etc.)	50% after ded (12-month waiting period) ³	20% after ded (1st year) 30% after ded (2nd year) 50% after ded (subsequent years)	Not covered	Not covered
Enrollment Fee	Yes	Yes	No	No
	→ Benefit summary	→ Benefit summary	→ Benefit summary	→ Benefit summary

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 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

UTAH

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

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

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2. May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

UTAH

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

VERMONT

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-rays²)

Discounts for dental services at 20-40%

Basic services

(includes services, such as fillings)

Discounted fees with in-network provider

Major services

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

Discounted fees with in-network provider

Enrollment Fee

Yes

[→ Benefit summary](#)

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2. May vary by plan; see benefit summary for more specific coverage details.

[For additional information 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

VIRGINIA

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

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
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 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

VIRGINIA

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

WEST VIRGINIA

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

1. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
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 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

WEST VIRGINIA

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

Humana Vision	
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

WISCONSIN

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

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

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

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

3 Policy-holders who provide proof of 12 months prior coverage are 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 or to learn about out-of-network benefits, view the benefit summary linked above or contact your Humana sales representative.](#)

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→ [Rate Sheet Links](#)



Humana Individual Dental plans

WISCONSIN

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

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

Dental Discount¹

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. THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
2. May vary by plan; see benefit summary for more specific coverage details.

For additional information 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

WISCONSIN

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

	Humana Vision
Exam with dilation (as necessary)	\$15 copay
Contact lens exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$150 allowance, 20% after balance over \$150
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$150 allowance, 15% after balance over \$150
• Disposable	\$150 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 12 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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

WYOMING

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

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

- 1 THIS DENTAL DISCOUNT PLAN IS NOT INSURANCE. Services outlined above are not insurance and are subject to geographical availability and may be discontinued at any time.
- 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 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

WYOMING

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

	Focus
Exam with dilation (as necessary)	\$10 copay
Contact lenses exam options¹	
• Standard contact lens fit and follow-up	\$40 copay
• Premium contact lens fit and follow-up	10% off retail
Frames	\$100 allowance, 20% off balance over \$100
Standard plastic lenses	\$25 copay
Lens options	
• UV coating	\$15 copay
• Tint (solid and gradient)	\$15 copay
• Standard scratch-resistance	\$15 copay
• Standard polycarbonate ²	\$40 copay
• Standard anti-reflective coating	\$45 copay
• Standard progressive (add-on to bifocal)	\$65 copay
• Other add-ons and services	20% off retail price
Contact lenses	
• Conventional	\$115 allowance, 15% off balance over \$115
• Disposable	\$115 allowance
• Medically necessary (1 pair)	100%
Frequency (based on date of service)	
• Exam	Once every 12 months
• Lenses or contact lenses	Once every 12 months
• Frames	Once every 24 months
Enrollment Fee	Yes
	→ Benefit summary

1. **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 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's Individual dental and vision plans.

You can find marketing materials, such as brochures and flyers, in the Marketing Resource Center, 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 by market, 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 Humana's 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 (which is accessed through Agent Workbench).

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.)

Cancellation limitation - for PPO dental plans

The Free look period is 10 days (except New Hampshire which has a 30 day free look period). If the plan is cancelled within the free look period, the member will be refunded the premium. The enrollment fee (where applicable) is nonrefundable as allowed by state requirements. Your client will also be responsible for the

full cost of any services received during this time period. Many Humana individual dental and vision plans have a one year minimum contract; that information is available in the member's evidence of coverage (which can be accessed via the secure [humanaonemember.com](#) site.

For DHMO plans (Dental Value - H1215 or C550)

Applications: The member must choose a primary care dentist 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.)

See your state-specific summary of benefits for additional details.

Cancellation limitation - for DHMO dental plans (same as PPO plans)

Dental Savings Plus (discount plans)

Plan administration (same as PPO plans) Cancellation limitations (same as PPO plans)

ID cards - for all individual dental and vision 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.)

APPENDIX II:

Benefit summaries for Veterans:

State	Bright Plus for Veterans	Preventive Plus for Veterans
AL		→ Benefit summary
AR		→ Benefit summary
AZ	→ Benefit summary	
CA	→ Benefit summary	
CO	→ Benefit summary	
CT	→ Benefit summary	
DC	→ Benefit summary	
DE	→ Benefit summary	
FL	→ Benefit summary	
GA	→ Benefit summary	
IA		→ Benefit summary
ID	→ Benefit summary	
IL	→ Benefit summary	
IN		→ Benefit summary
KS	→ Benefit summary	
KY		→ Benefit summary
LA		→ Benefit summary
MA	→ Benefit summary	
MD		→ Benefit summary
ME		→ Benefit summary
MI	→ Benefit summary	
MN	→ Benefit summary	

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

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 applicaiton 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 Individual Dental and Vision insurance plans include:

- Paper Application Checklist (GCA0CS2HH)
- Generic Payment Form (GN-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. 4 & 5)	Bright Plus & Bright Plus for Veterans	Complete Dental	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 or AL-72027
AR	n/a	AR-72024 (dental+vision)	n/a	n/a	GN-71120	AR-72024
AZ	AZ-72024 (dental+vision)	AZ-72024 (dental+vision)	AZ-72024 (dental+vision)	AZ-72027 (dental+vision)	GN-71120	AZ-72024 or AZ-72027
CA	CA-72024 (dental+vision)	CA-72024 (dental+vision)	CA-72024 (dental+vision)	CA-72027 (dental+vision)	n/a	CA-72024 or CA-72027
CO	CO-72029 (dental)	CO-72002 (dental+vision)	CO-72029 (dental)	CO-72027 (dental)	GN-71120	CO-72002
CT	CT-72024 (dental+vision)	CT-72024 (dental+vision)	CT-72024 (dental+vision)	n/a	GN-71120	CT-72024
DC	DC-72029 (dental)	DC-72024 (dental+vision)	DC-72029 (dental)	n/a	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 (den- tal+vision)	FL-72024 (dental+vision)	FL-72027 (dental+vision)	GN-71120	FL-72024 or FL-72027
GA	GA-72024 (dental+vision)	GA-72024 (dental+vision)	GA-72024 (dental+vision)	GA-72027 (dental)	GN-71120	GA-72024
IA	n/a	IA-72024 (dental+vision)	n/a	n/a	GN-71120	IA-72024
ID	ID-72029 (dental)	ID-72002 (dental/vision)	ID-72029 (dental)	n/a	GN-71120	ID-72002
IL	IL-72024 (dental+vision)	IL-72024 (dental+vision)	IL-72024 (dental+vision)	IL-72027 (dental+vision)	GN-71120	IL-72024 or IL-72027
IN	n/a	IN-72024 (dental+vision)	n/a	IN-72027 (dental+vision)	GN-71120	IN-72024 or IN-72027
KS	KS-72024 (dental+vision)	KS-72024 (dental+vision)	KS-72024 (dental+vision)	KS-72027 (dental+vision)	GN-71120	KS-72024 or KS-72027
KY	n/a	KY-72024 (dental+vision)	n/a	KY-72027 (dental+vision)	GN-71120	KY-72024 or KY-72027
LA	n/a	LA-72024 (dental+vision)	n/a	LA-72027 (dental+vision)	GN-71120	LA-72024 or LA-72027
MA	MA-72029 (dental)	MA-72024 (dental+vision)	MA-72029 (dental)	n/a	GN-71120	MA-72024

State	Preventive Value	Loyalty Plus Preventive Plus Dental Value DHMO (see plan availability by state on pgs. 4 & 5)	Bright Plus & Bright Plus for Veterans	Complete Dental	Dental Savings Plus (Discount Only - Not Insurance)	Vision (if also purchasing dental see the dental info to choose the correct application)
MD	n/a	MD-72024 (dental)	n/a	n/a	GN-71120	MD-72002
ME	n/a	ME-72002 (dental+vision)	n/a	n/a	GN-71120	ME-72002
MI	MI-72024 (dental+vision)	MI-72024 (dental+vision)	MI-72024 (dental+vision)	n/a	GN-71120	MI-72024
MN	MN-72029 (dental)	MN-72002 (dental+vision)	MN-72029 (dental)	MN-72027 (dental)	GN-71120	MN-72002
MO	MO-72024 (dental+vision)	MO-72024 (dental+vision)	MO-72024 (dental+vision)	MO-72027 (dental+vision)	GN-71120	MO-72024 or MO-72027
MS	n/a	MS-72024 (dental+vision)	n/a	n/a	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 or NC-72027
ND		ND-72024 (dental+vision)	n/a	n/a	GN-71120	ND-72024
NE	NE-72024 (dental+vision)	NE-72024 (dental+vision)	NE-72024 (dental+vision)	n/a	GN-71120	NE-72024
NH	n/a	NH-72002 (dental)	n/a	n/a	GN-71120	NH-72002
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	GN-71120	NV-72024 (vision only app)
NY	NY-72002 (dental+vision)	NY-72002 (dental+vision)	NY-72002 (dental+vision)	n/a	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)	n/a	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)	GN-71120	PA-72024 or PA-72027
RI	n/a	n/a	n/a	n/a	GN-71120	
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 or TN-72027
TX	TX-72024 (dental+vision)	TX-72024 (dental+vision)	TX-72024 (dental+vision)	TX-72027 (dental+vision)	GN-71120	TX-72024 or TX-72027
UT	UT-72029 (dental)	UT-72002 (dental+vision)	UT-72029 (dental)	UT-72027 (dental)	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)	GN-71120	WI-72024 or WI-72027
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