

# Humana Individual Specialty Agent Plan Grid

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

*Revised April 2025*

## WHAT'S NEW?

New state launch:

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

Plans added for new sales in multiple states:

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

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

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GCHK38JEN 0425



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- Individual Vision plans

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# Humana Individual Specialty



**Click on a state to view:**

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



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

# Humana Individual Specialty

## Rate Sheet Links:

[Preventive Value](#)

[Preventive Plus](#)

[Preventive Plus for Veterans](#)

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

[Loyalty Plus](#)

[\\*Complete Dental](#)

[\\*Humana Extend](#)

[Dental Value C550](#)

[Dental Value HI215](#)

[Dental Savings Plus](#)

[On-Exchange Dental](#)

[\\*Humana Vision PLUS](#)

[Humana Vision](#)

[\\*Focus](#)

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

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



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



+ Indicates plans that have an enrollment fee

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

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

Continued on next page →

+ Indicates plans that have an enrollment fee

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

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



# Humana Individual Dental plans

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

|                                  | PPO <sup>2, 3</sup>                                                                                                                                                                                            |                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                  |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                  | Preventive Value<br>(off-exchange)                                                                                                                                                                             | Preventive Plus<br>(off-exchange)                                                                                                                                                                                        | Bright Plus<br>(off-exchange)                                                                                                                                                                                                                                                         | Loyalty Plus<br>(off-exchange)                                                                                                                                                                                                                        | Complete Dental<br>(off-exchange)                                                                                                                                                                                                                                                                                |
| <b>Generally a good fit for:</b> | Budget-conscious individuals who know the importance of preventive dental care, and appreciate a straightforward plan covering preventive and basic services.                                                  | Individuals who know the importance of preventive dental care and want some coverage for unexpected dental needs.<br><br>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.<br><br>A great balance to help maintain healthy teeth and gums, and a beautiful smile.                                                                              | Individuals who want immediate coverage even if they haven't had prior dental coverage.                                                                                                                                                               | Individuals who want robust coverage. Richest benefits may be available immediately for those who have had eligible prior dental coverage.                                                                                                                                                                       |
| <b>Plan highlights:</b>          | <ul style="list-style-type: none"> <li>• No waiting periods</li> <li>• One-time deductible for as long as they have the plan</li> <li>• Coverage for preventive and basic services after deductible</li> </ul> | <ul style="list-style-type: none"> <li>• 100% coverage of two covered preventive cleanings and exams per year</li> <li>• Coverage for services like fillings and extractions after a six-month waiting period</li> </ul> | <ul style="list-style-type: none"> <li>• 100% coverage of two covered preventive cleanings and exams per year</li> <li>• Coverage for services like fillings and extractions after a 90 day waiting period</li> <li>• \$100 annual allowance for in-office teeth whitening</li> </ul> | <ul style="list-style-type: none"> <li>• No waiting periods</li> <li>• One-time deductible for as long as they have the plan</li> <li>• Covers preventive, basic and major services</li> <li>• Increasing benefits from years one to three</li> </ul> | <ul style="list-style-type: none"> <li>• Comprehensive coverage (100% preventive, 80% basic services, 50% major services)</li> <li>• Coverage in- and out-of-network</li> <li>• Waiting periods apply to basic and major services and may be waived with evidence of prior dental insurance coverage.</li> </ul> |

<sup>1</sup> Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. In New Mexico: This is a limited policy. This is a dental only policy. In Pennsylvania: You may sometimes see elimination period referred to as waiting period.

<sup>2</sup> In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.

<sup>3</sup> Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.

→ [Dental provider directory](#)

For Agent Use Only.

 Humana Individual Dental plans (continued)

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

|                                  | DHMO                                                                                                                                                                                                                           | Dental Discount <sup>2</sup>                                                                                                                                                                                                                                        | PPO <sup>3, 4</sup>                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                  | Dental Value<br>(C550 & HI215)<br>(off-exchange)                                                                                                                                                                               | Dental Savings Plus<br>(off-exchange)                                                                                                                                                                                                                               | On-Exchange Dental                                                                                                                                                                                                                                                                                                                                                                |
| <b>Generally a good fit for:</b> | Budget-conscious individuals who want coverage, and want to know their costs upfront.                                                                                                                                          | For individuals who want some savings in dental care, but don't want to invest in dental insurance.                                                                                                                                                                 | Consumers looking to enroll in a plan offered on the Marketplace thru the Federally Facilitated or State-Based Exchange (varies by state).                                                                                                                                                                                                                                        |
| <b>Plan highlights:</b>          | <ul style="list-style-type: none"> <li>No waiting periods</li> <li>No deductible</li> <li>No annual maximum</li> <li>Covers preventive, basic and major services</li> <li>Member must choose a primary care dentist</li> </ul> | <ul style="list-style-type: none"> <li>In-network providers offer discounts on covered dental services (ranging from 20-40%)</li> <li>Special discounts on prescriptions, alternative medicine, vision and hearing</li> <li><b>This is not insurance</b></li> </ul> | <ul style="list-style-type: none"> <li>100% coverage for most preventive services by visiting an in-network provider</li> <li>Plans sold on Healthcare.gov or a State-Based Exchange (varies by state)</li> <li>Low deductibles</li> <li>In most states, the consumer must be enrolled in a medical on-exchange plan in order to select a dental plan on the exchange.</li> </ul> |

1 Individual plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. In New Mexico: This is a limited policy. This is a dental only policy. In Pennsylvania: You may sometimes see elimination period referred to as waiting period.

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

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

4 Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.

→ [Dental provider directory](#)

For Agent Use Only.

# Individual Humana Extend (DVH) plans

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

|                                  | PPO <sup>2, 3</sup>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                  | Humana Extend 1250<br>(off-exchange)                                                                                                                                                                                                                                                                                     | Humana Extend 2500<br>(off-exchange)                                                                                                                                                                                                                                                                                                                                    | Humana Extend 5000<br>(off-exchange)                                                                                                                                                                                                                                                                                                                                                              |
| <b>Generally a good fit for:</b> | Individuals who want one plan with comprehensive dental coverage with vision <sup>4</sup> and hearing.                                                                                                                                                                                                                   | Individuals who want one plan with comprehensive dental coverage with vision <sup>4</sup> and hearing. Also includes coverage for dental implants.                                                                                                                                                                                                                      | Individuals who want one plan with comprehensive dental coverage with vision <sup>4</sup> and hearing. Higher annual maximum. Also includes coverage for dental implants.                                                                                                                                                                                                                         |
| <b>Plan highlights:</b>          | <ul style="list-style-type: none"> <li>• \$1,250 annual maximum</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 60% basic services, 30% major services)</li> <li>• Coverage for vision exams</li> <li>• Coverage for hearing exam and hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• \$2,500 annual maximum</li> <li>• Coverage for implants</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 80% basic services, 50% major services)</li> <li>• Coverage for vision exams and materials</li> <li>• Coverage for hearing exam and hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• \$5,000 annual maximum</li> <li>• Coverage for implants</li> <li>• Annual allowance for teeth whitening</li> <li>• Comprehensive dental coverage (100% preventive, 80% basic services, 50% year 1 and 60% year 2 for major services)</li> <li>• Coverage for vision exams and materials</li> <li>• Coverage for hearing exam and hearing aids</li> </ul> |

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

<sup>2</sup> In Texas, the plans provide benefits for contracted and non-contracted dentists. Non-contracted dentists have not agreed to provide services at contracted fees. If a member sees a non-contracted dentist, their out of pocket costs may be higher than that charged by contracted dentists.

<sup>3</sup> Dental PPO plans are not offered in all states. Members have access to a broad nationwide network.

<sup>4</sup> Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

→ [Dental provider directory](#) → [Vision provider directory](#) → [Hearing resources](#)

For Agent Use Only.

# Humana Individual Vision plans

Plans vary by state.  
See state pages for more detail.<sup>1, 2</sup>

|                  | PPO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                  | Humana Vision<br>Humana Vision PLUS<br>(off-exchange)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Vision Care Plan (VCP)<br>(off-exchange)                                                                                                                                                                                                                                                                                                                                            | Focus<br>(off-exchange)                                                                                                                                                                                                                                                                                                                                                                                     |
| Plan highlights: | <ul style="list-style-type: none"><li>Comprehensive eye exam once a year</li><li>Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical®</li><li>Frame allowance every 12 months</li><li>Lens or contact lens benefit</li><li>Lasik discounts</li><li>Enhanced benefits when visiting a PLUS provider for members enrolled on a Humana Vision PLUS plan</li></ul> | <ul style="list-style-type: none"><li>Comprehensive eye exam once a year</li><li>Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical®</li><li>Frame allowance every 24 months</li><li>Lens or contact lens benefit</li></ul> | <ul style="list-style-type: none"><li>Comprehensive eye exam once a year</li><li>Large network with optometrists and ophthalmologists at more than 170,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision® and Target Optical®</li><li>Frame allowance every 24 months</li><li>Lens or contact lens benefit</li><li>Lasik Discounts</li></ul> |

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

→ [Vision provider directory](#)

For Agent Use Only.



# Humana Individual Dental plans

ALABAMA

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

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

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

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

Jump to:  
→ [Rate Sheet Links](#)

[Additional dental plan options](#) →

# Humana Individual Dental plans

## ALABAMA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |                                            |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|--------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) |                   |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            | Adult                                      | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$35 (per child)                     | \$35 (per adult)                          | \$35 (per child)                     | \$80 (per adult)                           | \$35 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                        | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       | 100% after ded                             | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                                | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        | Not covered                                | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   | No                                         | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>          |                   |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

## ALABAMA

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

ALABAMA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

ALASKA

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

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

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

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# Humana Individual Dental plans

ARIZONA

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

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

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

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

**Additional dental plan options** →

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# Humana Individual Dental plans

ARIZONA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

ARIZONA

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

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

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

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

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

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# Humana Individual Vision plan

ARIZONA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

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

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## ARKANSAS

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

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

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

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

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

ARKANSAS

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## CALIFORNIA

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

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

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

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

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

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

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# Humana Individual Dental plans

CALIFORNIA

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

|                                                                                                           | PPO                                                                                                                                        |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
|                                                                                                           | Family Dental PPO<br>(on-exchange, 2025)                                                                                                   |                                      |
|                                                                                                           | Adult                                                                                                                                      | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                                                                                                                           | \$75 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,500 (per adult)                                                                                                                        | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                                                                                                                | 100% no ded                          |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 80% after ded                                                                                                                              | 80% after ded                        |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 50% after ded<br>(6-month waiting period)                                                                                                  | 50% after ded<br>(no waiting period) |
| <b>Enrollment Fee</b>                                                                                     | No                                                                                                                                         | No                                   |
|                                                                                                           | <b>Benefit summary</b> → <a href="#">ENG</a> → <a href="#">SPA</a><br><b>Disclosure matrix</b> → <a href="#">ENG</a> → <a href="#">SPA</a> |                                      |

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

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

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# Individual Humana Extend plans

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

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

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

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

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

[Vision plan option](#) →



# Humana Individual Vision plan

CALIFORNIA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                              | Humana Vision PLUS                                                                                                                  |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <b>Benefit Summary</b> → <a href="#">ENG</a> → <a href="#">SPA</a>                                                                  |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

COLORADO

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

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

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

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

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

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

5 The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/Dental ID card and requesting a copy.

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

Jump to:

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# Individual Humana Extend plans

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

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

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

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

3 The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/Dental ID card and requesting a copy.

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

[Vision plan option](#) 

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# Humana Individual Vision plan

COLORADO

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS <sup>4</sup>              |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.
- The Network Access Plan, which describes an access plan specific to the network, is available by calling the customer service number found on the Humana Vision ID Card/ Dental ID card and requesting a copy.

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

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# Humana Individual Dental plans

## CONNECTICUT

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

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

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

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

CONNECTICUT

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

DELAWARE

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

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

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

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

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

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

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

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# Individual Humana Extend plans

## DELAWARE

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

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

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

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

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



# Humana Individual Vision plan

DELAWARE

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | <a href="#">→ Benefit summary</a>           |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$40.

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

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

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

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

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | → <a href="#">Benefit summary</a>           |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$40.

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

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# Humana Individual Dental plans

FLORIDA

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

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

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

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

[Additional dental plan options](#) →

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# Humana Individual Dental plans

## FLORIDA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |                                            |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|--------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) |                   |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            | Adult                                      | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$55 (per child)                     | \$50 (per adult)                          | \$55 (per child)                     | \$80 (per adult)                           | \$55 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                        | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       | 100% after ded                             | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                                | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        | Not covered                                | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   | No                                         | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>          |                   |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

FLORIDA

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

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

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

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

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

[Vision plan option](#) →

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# Humana Individual Vision plan

FLORIDA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

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

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

GEORGIA

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

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

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

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

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# Humana Individual Dental plans

GEORGIA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice - High<br>(on-exchange, 2025) |                                      | Smart Choice - Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% after ded                            | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 50% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

GEORGIA

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

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

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

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

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

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# Humana Individual Vision plan

GEORGIA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0                                                                                                                                 |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

HAWAII

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

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

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

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

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# Humana Individual Dental plans

HAWAII

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

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

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

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

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

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

# Humana Individual Vision plan

HAWAII

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

IDAHO

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

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

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

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

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

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

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

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# Humana Individual Dental plans

IDAHO

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

IDAHO

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

IDAHO

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

ILLINOIS

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

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

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

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

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# Humana Individual Dental plans

ILLINOIS

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |                                                         |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|---------------------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) <sup>1</sup> |                   |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            | Adult                                                   | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$25 (per adult)                           | \$25 (per child)                     | \$25 (per adult)                          | \$25 (per child)                     | \$60 (per adult)                                        | \$25 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                                     | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>2</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       | 100% after ded                                          | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 70% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                                             | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 50% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        | Not covered                                             | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   | No                                                      | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>                       |                   |

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

ILLINOIS

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## INDIANA

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

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

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

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

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

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

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

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# Humana Individual Dental plans

## INDIANA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

## INDIANA

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

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

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

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

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



# Humana Individual Vision plan

INDIANA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

IOWA

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

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

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

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

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

IOWA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

KANSAS

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

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

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

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

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

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

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

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# Individual Humana Extend plans

KANSAS

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

KANSAS

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## KENTUCKY

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

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

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

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

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

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

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

# Individual Humana Extend plans

KENTUCKY

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

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

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

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

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



# Humana Individual Vision plan

KENTUCKY

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

LOUISIANA

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

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

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

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

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

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

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

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# Humana Individual Dental plans

LOUISIANA

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

|                                                                                                           | PPO                                       |                                      |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice<br>(on-exchange, 2025)       |                                      |
|                                                                                                           | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$45 (per adult)                          | \$45 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

LOUISIANA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

MAINE

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

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

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

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

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

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

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

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# Humana Individual Vision plan

MAINE

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## MARYLAND

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

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

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

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

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

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

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

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# Individual Humana Extend plans

MARYLAND

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

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

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

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

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

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# Humana Individual Vision plan

MARYLAND

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0                                                                                                                                 |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

MASSACHUSETTS

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

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

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

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

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

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# Humana Individual Vision plan

MASSACHUSETTS

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | → <a href="#">Benefit summary</a>           |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$40.

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

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# Humana Individual Dental plans

MICHIGAN

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

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

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

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

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

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

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

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# Humana Individual Dental plans

MICHIGAN

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

|                                                                                                           | PPO                                       |                                      |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice<br>(on-exchange, 2025)       |                                      |
|                                                                                                           | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$40 (per adult)                          | \$40 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000                                   | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

MICHIGAN

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

MICHIGAN

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## MINNESOTA

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

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

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

MINNESOTA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                              | Humana Vision PLUS                                                                                                                  |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

MISSISSIPPI

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

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

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

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

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

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

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

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# Humana Individual Dental plans

MISSISSIPPI

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$25 (per adult)                           | \$25 (per child)                     | \$25 (per adult)                          | \$25 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% after ded                            | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 50% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

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

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

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# Individual Humana Extend plans

MISSISSIPPI

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

MISSISSIPPI

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## MISSOURI

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

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

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

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

[Additional dental plan options](#) →

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# Humana Individual Dental plans

MISSOURI

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

|                                                                                                           | PPO                                       |                                      |                                                         |                   |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|---------------------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) <sup>1</sup> |                   |
|                                                                                                           | Adult                                     | Pediatric                            | Adult                                                   | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$45 (per adult)                          | \$45 (per child)                     | \$100 (per adult)                                       | \$45 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                                     | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>2</sup> ) | 100% no ded                               | 100% after ded                       | 100% after ded                                          | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) | Not covered                                             | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | 50% after ded                        | Not covered                                             | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                                   | No                                                      | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>                       |                   |

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

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

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# Individual Humana Extend plans

## MISSOURI

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

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

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

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

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



# Humana Individual Vision plan

MISSOURI

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

MONTANA

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

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

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

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

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

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# Humana Individual Dental plans

## NEBRASKA

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

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

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

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

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

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

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

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# Individual Humana Extend plans

NEBRASKA

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

NEBRASKA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Vision plan

NEVADA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | <a href="#">→ Benefit summary</a>           |

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

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

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

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

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# Humana Individual Dental plans

NEW HAMPSHIRE

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

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

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

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

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# Humana Individual Vision plan

NEW HAMPSHIRE

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

NEW JERSEY

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

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

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

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

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

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

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# Humana Individual Vision plan

NEW JERSEY

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | → <a href="#">Benefit summary</a>           |

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

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

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

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

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# Humana Individual Dental plans

## NEW MEXICO

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

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

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

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

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

4 This is a limited policy. This is a dental only policy.

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

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

## Individual Humana Extend plans

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

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

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

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

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# Humana Individual Vision plan

NEW MEXICO

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                                                                                                                                                                                                                                                                                                      | Humana Vision PLUS <sup>4</sup>                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)                                                                                                                                                                                                                                                                                             | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> <ul style="list-style-type: none"> <li>Standard contact lens fit and follow-up</li> <li>Premium contact lens fit and follow-up</li> </ul>                                                                                                                                               | \$0 copay<br>10% off retail                                                                                                         |
| <b>Frames</b>                                                                                                                                                                                                                                                                                                                        | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>                                                                                                                                                                                                                                                                                                       | \$10 copay                                                                                                                          |
| <b>Lens options</b> <ul style="list-style-type: none"> <li>UV coating</li> <li>Tint (solid and gradient)</li> <li>Standard scratch-resistance</li> <li>Standard polycarbonate<sup>3</sup></li> <li>Standard anti-reflective coating</li> <li>Standard progressive (add-on to bifocal)</li> <li>Other add-ons and services</li> </ul> | \$0 copay<br>\$0 copay<br>\$0 copay<br>\$20 copay<br>\$25 copay<br>\$65 copay<br>20% off retail price                               |
| <b>Contact lenses</b> <ul style="list-style-type: none"> <li>Conventional</li> <li>Disposable</li> <li>Medically necessary (1 pair)</li> </ul>                                                                                                                                                                                       | \$200 allowance, 15% after balance over \$200<br>\$200 allowance<br>\$0 copay                                                       |
| <b>Frequency</b> (based on date of service) <ul style="list-style-type: none"> <li>Exam</li> <li>Lenses or contact lenses</li> <li>Frames</li> </ul>                                                                                                                                                                                 | Once every 12 months<br>Once every 12 months<br>Once every 12 months                                                                |
| <b>Enrollment Fee</b>                                                                                                                                                                                                                                                                                                                | No                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                      | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.
- This is a limited policy. This is a vision only policy.

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

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# Humana Individual Dental plans

NEW YORK

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

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

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

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

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

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# Individual Humana Extend plans

NEW YORK

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

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

- 1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.
- 2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

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



# Humana Individual Vision plan

NEW YORK

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | → <a href="#">Benefit summary</a>           |

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

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

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

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

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# Humana Individual Dental plans

NORTH CAROLINA

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

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

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

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

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# Humana Individual Dental plans

NORTH CAROLINA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |                                            |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|--------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) |                   |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            | Adult                                      | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     | \$80 (per adult)                           | \$50 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                        | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       | 100% after ded                             | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                                | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        | Not covered                                | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   | No                                         | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>          |                   |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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## Individual Humana Extend plans

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

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

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

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

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

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 Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision                                |                                               |
|----------------------------------------------|-----------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$15 copay                                    |
| <b>Contact lens exam options<sup>2</sup></b> |                                               |
| • Standard contact lens fit and follow-up    | \$40 copay                                    |
| • Premium contact lens fit and follow-up     | 10% off retail                                |
| <b>Frames</b>                                | \$150 allowance, 20% after balance over \$150 |
| <b>Standard plastic lenses</b>               | \$25 copay                                    |
| <b>Lens options</b>                          |                                               |
| • UV coating                                 | \$15 copay                                    |
| • Tint (solid and gradient)                  | \$15 copay                                    |
| • Standard scratch-resistance                | \$15 copay                                    |
| • Standard polycarbonate <sup>3</sup>        | \$40 copay                                    |
| • Standard anti-reflective coating           | \$45 copay                                    |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                    |
| • Other add-ons and services                 | 20% off retail price                          |
| <b>Contact lenses</b>                        |                                               |
| • Conventional                               | \$150 allowance, 15% after balance over \$150 |
| • Disposable                                 | \$150 allowance                               |
| • Medically necessary (1 pair)               | 100%                                          |
| <b>Frequency</b> (based on date of service)  |                                               |
| • Exam                                       | Once every 12 months                          |
| • Lenses or contact lenses                   | Once every 12 months                          |
| • Frames                                     | Once every 12 months                          |
| <b>Enrollment Fee</b>                        | Yes                                           |
|                                              | → <a href="#">Benefit summary</a>             |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$40.

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

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# Humana Individual Dental plans

NORTH DAKOTA

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

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

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

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

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

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

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

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# Humana Individual Vision plan

NORTH DAKOTA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | <a href="#">→ Benefit summary</a>           |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$40.

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

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# Humana Individual Dental plans

OHIO

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

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

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

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

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

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

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[Additional dental plan options](#) →



# Humana Individual Dental plans

OHIO

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

|                                                                                                           | PPO                                       |                                      |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice<br>(on-exchange, 2025)       |                                      |
|                                                                                                           | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$35 (per adult)                          | \$35 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

OHIO

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

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

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

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

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

# Humana Individual Vision plan

OHIO

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

OKLAHOMA

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

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

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

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

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

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

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

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# Humana Individual Dental plans

OKLAHOMA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% no ded                          |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 70% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 70% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 70% after ded<br>(no waiting period) | Not covered                               | 70% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

OKLAHOMA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## OREGON

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

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

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

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

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

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# Humana Individual Dental plans

## PENNSYLVANIA

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

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

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

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

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[Additional dental plan options](#) →



# Humana Individual Dental plans

PENNSYLVANIA

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

|                                                                                                           | PPO                                                                |                                                       |                                                                    |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025)                         |                                                       | Smart Choice – Low<br>(on-exchange, 2025)                          |                   |
|                                                                                                           | Adult                                                              | Pediatric                                             | Adult                                                              | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                                                   | \$50 (per child)                                      | \$50 (per adult)                                                   | \$50 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                                                | No annual maximum                                     | \$1,000 (per adult)                                                | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                                        | 100% no ded                                           | 100% no ded                                                        | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded                                                      | 80% after ded                                         | 60% after ded                                                      | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month elimination period) <sup>2</sup>        | 50% after ded<br>(no elimination period) <sup>2</sup> | Not covered                                                        | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                                                 | No                                                    | No                                                                 | No                |
|                                                                                                           | <b>Benefit summary</b> → <a href="#">ENG</a> → <a href="#">SPA</a> |                                                       | <b>Benefit summary</b> → <a href="#">ENG</a> → <a href="#">SPA</a> |                   |

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

2 You may sometimes see elimination periods referred to as waiting periods.

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

PENNSYLVANIA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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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-rays<sup>2</sup>)

Discounts for dental services at 20-40%

**Basic services**

(includes services, such as fillings)

Discounted fees with in-network provider

**Major services**

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

Discounted fees with in-network provider

**Enrollment Fee**

Yes

[→ Benefit summary](#)

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

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

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

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# Humana Individual Dental plans

SOUTH CAROLINA

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

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

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

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

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

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 Humana Individual Vision plan

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Vision Care Plan (VCP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$10 copay                                           |
| <b>Frames</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$120 allowance, 20% discount off balance over \$120 |
| <b>Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$0 copay                                            |
| <b>Contact lenses<sup>2</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |
| • Elective (conventional and disposable) <sup>3</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$115 allowance                                      |
| • Medically necessary (1 pair) <sup>4</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 100%                                                 |
| <b>Frequency</b> (based on date of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      |
| • Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Once every 12 months                                 |
| • Lenses or contact lenses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Once every 12 months                                 |
| • Frames                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Once every 24 months                                 |
| <b>Enrollment Fee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Yes                                                  |
| <b>Additional plan discounts:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |
| <ul style="list-style-type: none"> <li>members receive discounts on lens options including: anti reflective and scratch-resistant coatings.</li> <li>members also receive a 20 percent discount on a second pair of eyeglasses. This is available for 12 months after the covered eye exam and available through the VCP network providers who sold the initial pair of eyeglasses.</li> <li>after copay, standard polycarbonate available at no charge for dependents less than 19 years old.</li> </ul> |                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <a href="#">→ Benefit summary</a>                    |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).
- 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.
- Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

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

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# Humana Individual Dental plans

SOUTH DAKOTA

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

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

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

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

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## Individual Humana Extend plans

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

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

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

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

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

[Vision plan option](#) 

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# Humana Individual Vision plan

SOUTH DAKOTA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

TENNESSEE

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

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

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

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

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

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

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# Humana Individual Dental plans

TENNESSEE

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

|                                                                                                           | PPO                                        |                                      |                                           |                   |                                            |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|-------------------|--------------------------------------------|-------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                   | Smart Choice – Lite<br>(on-exchange, 2025) |                   |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric         | Adult                                      | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$25 (per adult)                           | \$25 (per child)                     | \$25 (per adult)                          | \$25(per child)   | \$50 (per adult)                           | \$25 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum | \$1,000 (per adult)                        | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded    | 100% after ded                             | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded                             | 50% after ded     | Not covered                                | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded     | Not covered                                | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                | No                                         | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                   | <a href="#">→ Benefit summary</a>          |                   |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

TENNESSEE

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

## TEXAS

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

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

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

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

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

Additional dental plan options →

 Humana Individual Dental plans

# TEXAS

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

|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      | Smart Choice – Lite<br>(on-exchange, 2025) |                   |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|--------------------------------------------|-------------------|
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            | Adult                                      | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$80 (per adult)                           | \$60 (per child)                     | \$80 (per adult)                          | \$80 (per child)                     | \$100 (per adult)                          | \$80 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    | \$1,000 (per adult)                        | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       | 100% after ded                             | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 80% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                                | 50% after ded     |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        | Not covered                                | 50% after ded     |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   | No                                         | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      | <a href="#">→ Benefit summary</a>          |                   |

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

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

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

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# Individual Humana Extend plans

TEXAS

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

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

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

- 1 Humana Extend 5000 only: Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period (with the exception of implants). Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.
- 2 Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.

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

[Vision plan option](#) →

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# Humana Individual Vision plan

TEXAS

When visiting a contracted provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                                                 |                                               |
|--------------------------------------------------------------------|-----------------------------------------------|
| <b>Exam with dilation</b> (as necessary)                           | \$0 copay                                     |
| <b>Contact lens exam options<sup>2</sup></b>                       |                                               |
| • Standard contact lens fit and follow-up                          | \$0                                           |
| • Premium contact lens fit and follow-up                           | 10% off retail                                |
| <b>Frames</b>                                                      | \$250 allowance, 20% after balance over \$250 |
| <b>Standard plastic lenses</b>                                     | \$10 copay                                    |
| <b>Lens options</b>                                                |                                               |
| • UV coating                                                       | \$0 copay                                     |
| • Tint (solid and gradient)                                        | \$0 copay                                     |
| • Standard scratch-resistance                                      | \$0 copay                                     |
| • Standard polycarbonate <sup>3</sup>                              | \$20 copay                                    |
| • Standard anti-reflective coating                                 | \$25 copay                                    |
| • Standard progressive (add-on to bifocal)                         | \$65 copay                                    |
| • Other add-ons and services                                       | 20% off retail price                          |
| <b>Contact lenses</b>                                              |                                               |
| • Conventional                                                     | \$200 allowance, 15% after balance over \$200 |
| • Disposable                                                       | \$200 allowance                               |
| • Medically necessary (1 pair)                                     | \$0 copay                                     |
| <b>Frequency</b> (based on date of service)                        |                                               |
| • Exam                                                             | Once every 12 months                          |
| • Lenses or contact lenses                                         | Once every 12 months                          |
| • Frames                                                           | Once every 12 months                          |
| <b>Enrollment Fee</b>                                              | No                                            |
| <b>Benefit summary</b> → <a href="#">ENG</a> → <a href="#">SPA</a> |                                               |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

UTAH

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

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

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

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

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

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

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# Humana Individual Dental plans

UTAH

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

|                                                                                                           | PPO                                       |                   |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------|
|                                                                                                           | Smart Choice<br>(on-exchange, 2025)       |                   |
|                                                                                                           | Adult                                     | Pediatric         |
| <b>Deductible</b> (ded)                                                                                   | \$45 (per adult)                          | \$45 (per child)  |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                       | No annual maximum |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>2</sup> ) | 100% no ded                               | 100% after ded    |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 60% after ded<br>(6-month waiting period) | Not covered       |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | Not covered       |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                   |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

UTAH

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

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

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

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

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

# Humana Individual Vision plan

UTAH

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

VERMONT

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

|                                                                                                           | PPO                                                    | Dental Discount <sup>1</sup>             |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------|
|                                                                                                           | Complete Dental<br>(off-exchange)                      | Dental Savings Plus<br>(off-exchange)    |
| <b>Deductible</b> (ded)                                                                                   | Annual ded:<br>\$50 (individual)<br>\$150 (family)     | No ded                                   |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,250 (1st year)<br>\$1,500 (subsequent years)       | No annual maximum                        |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>2</sup> ) | 100% no ded                                            | Discounts for dental services at 20-40%  |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 80% after ded<br>(6-month waiting period) <sup>3</sup> | Discounted fees with in-network provider |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 50% after ded<br>(6-month waiting period) <sup>3</sup> | Discounted fees with in-network provider |
| <b>Enrollment Fee</b>                                                                                     | No                                                     | Yes                                      |
|                                                                                                           | <a href="#">→ Benefit summary</a>                      | <a href="#">→ Benefit summary</a>        |

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

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

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# Humana Individual Dental plans

VIRGINIA

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

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

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

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

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

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

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

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[Additional dental plan options](#) →



# Humana Individual Dental plans

VIRGINIA

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

|                                                                                                           | PPO                                        |                                      |                                           |                                      |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice – High<br>(on-exchange, 2025) |                                      | Smart Choice – Low<br>(on-exchange, 2025) |                                      |
|                                                                                                           | Adult                                      | Pediatric                            | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                           | \$50 (per child)                     | \$50 (per adult)                          | \$50 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                        | No annual maximum                    | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% no ded                                | 100% no ded                          | 100% no ded                               | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 70% after ded<br>(6-month waiting period)  | 80% after ded<br>(no waiting period) | 60% after ded<br>(6-month waiting period) | 50% after ded<br>(no waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | 40% after ded<br>(12-month waiting period) | 50% after ded<br>(no waiting period) | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                         | No                                   | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>          |                                      | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

VIRGINIA

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

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

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

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

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

# Humana Individual Vision plan

VIRGINIA

When visiting an in-network provider, members receive the following benefits: <sup>1</sup>

|                                                | Focus                                       |
|------------------------------------------------|---------------------------------------------|
| <b>Exam with dilation</b> (as necessary)       | \$10 copay                                  |
| <b>Contact lenses exam options<sup>2</sup></b> |                                             |
| • Standard contact lens fit and follow-up      | \$40 copay                                  |
| • Premium contact lens fit and follow-up       | 10% off retail                              |
| <b>Frames</b>                                  | \$100 allowance, 20% off balance over \$100 |
| <b>Standard plastic lenses</b>                 | \$25 copay                                  |
| <b>Lens options</b>                            |                                             |
| • UV coating                                   | \$15 copay                                  |
| • Tint (solid and gradient)                    | \$15 copay                                  |
| • Standard scratch-resistance                  | \$15 copay                                  |
| • Standard polycarbonate <sup>3</sup>          | \$40 copay                                  |
| • Standard anti-reflective coating             | \$45 copay                                  |
| • Standard progressive (add-on to bifocal)     | \$65 copay                                  |
| • Other add-ons and services                   | 20% off retail price                        |
| <b>Contact lenses</b>                          |                                             |
| • Conventional                                 | \$115 allowance, 15% off balance over \$115 |
| • Disposable                                   | \$115 allowance                             |
| • Medically necessary (1 pair)                 | 100%                                        |
| <b>Frequency</b> (based on date of service)    |                                             |
| • Exam                                         | Once every 12 months                        |
| • Lenses or contact lenses                     | Once every 12 months                        |
| • Frames                                       | Once every 24 months                        |
| <b>Enrollment Fee</b>                          | Yes                                         |
|                                                | → <a href="#">Benefit summary</a>           |

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

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

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

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

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# Humana Individual Dental plans

WASHINGTON

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

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

<sup>2</sup> Policyholders who provide proof of 12 months prior coverage may be exempt from this waiting period. Prior coverage is defined as an insurance plan that offered coverage and benefits. Discount plans are not considered prior coverage.

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

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# Humana Individual Dental plans

WEST VIRGINIA

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

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

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

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

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# Humana Individual Vision plan

WEST VIRGINIA

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

WISCONSIN

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

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

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

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

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

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

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

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# Humana Individual Dental plans

WISCONSIN

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

|                                                                                                           | PPO                                       |                                      |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|
|                                                                                                           | Smart Choice<br>(on-exchange, 2025)       |                                      |
|                                                                                                           | Adult                                     | Pediatric                            |
| <b>Deductible</b> (ded)                                                                                   | \$50 (per adult)                          | \$85 (per child)                     |
| <b>Annual maximum</b><br>(Maximum amount the plan will pay during the calendar year)                      | \$1,000 (per adult)                       | No annual maximum                    |
| <b>Preventive services</b><br>(includes services, such as oral exams, cleanings and X-rays <sup>1</sup> ) | 100% after ded                            | 100% after ded                       |
| <b>Basic services</b><br>(includes services, such as fillings)                                            | 50% after ded<br>(6-month waiting period) | 50% after ded<br>(No waiting period) |
| <b>Major services</b><br>(includes services, such as crowns, root canals, dentures, etc.)                 | Not covered                               | 50% after ded                        |
| <b>Enrollment Fee</b>                                                                                     | No                                        | No                                   |
|                                                                                                           | <a href="#">→ Benefit summary</a>         |                                      |

<sup>1</sup> May vary by plan; see benefit summary for more specific coverage details.

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

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# Individual Humana Extend plans

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

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

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

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

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



# Humana Individual Vision plan

WISCONSIN

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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# Humana Individual Dental plans

WYOMING

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

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

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

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

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# Individual Humana Extend plans

WYOMING

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

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

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

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

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

[Vision plan option](#) 

Jump to:  
→ [Rate Sheet](#)  
[Links](#)

# Humana Individual Vision plan

WYOMING

When visiting an in-network provider, members receive the following benefits:<sup>1</sup>

| Humana Vision PLUS                           |                                                                                                                                     |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exam with dilation</b> (as necessary)     | \$10 copay <i>or \$0 copay when visiting a PLUS provider</i>                                                                        |
| <b>Contact lens exam options<sup>2</sup></b> |                                                                                                                                     |
| • Standard contact lens fit and follow-up    | \$0 copay                                                                                                                           |
| • Premium contact lens fit and follow-up     | 10% off retail                                                                                                                      |
| <b>Frames</b>                                | \$200 allowance, 20% after balance over \$200 <i>or \$250 allowance, 20% after balance over \$250 when visiting a PLUS provider</i> |
| <b>Standard plastic lenses</b>               | \$10 copay                                                                                                                          |
| <b>Lens options</b>                          |                                                                                                                                     |
| • UV coating                                 | \$0 copay                                                                                                                           |
| • Tint (solid and gradient)                  | \$0 copay                                                                                                                           |
| • Standard scratch-resistance                | \$0 copay                                                                                                                           |
| • Standard polycarbonate <sup>3</sup>        | \$20 copay                                                                                                                          |
| • Standard anti-reflective coating           | \$25 copay                                                                                                                          |
| • Standard progressive (add-on to bifocal)   | \$65 copay                                                                                                                          |
| • Other add-ons and services                 | 20% off retail price                                                                                                                |
| <b>Contact lenses</b>                        |                                                                                                                                     |
| • Conventional                               | \$200 allowance, 15% after balance over \$200                                                                                       |
| • Disposable                                 | \$200 allowance                                                                                                                     |
| • Medically necessary (1 pair)               | \$0 copay                                                                                                                           |
| <b>Frequency</b> (based on date of service)  |                                                                                                                                     |
| • Exam                                       | Once every 12 months                                                                                                                |
| • Lenses or contact lenses                   | Once every 12 months                                                                                                                |
| • Frames                                     | Once every 12 months                                                                                                                |
| <b>Enrollment Fee</b>                        | No                                                                                                                                  |
|                                              | <a href="#">→ Benefit summary</a>                                                                                                   |

- Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts are available.
- 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 up to 19 years old. All other members pay a fixed charge of \$20.

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

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## APPENDIX I:

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

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

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

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

### Important Billing and Enrollment information:

#### Applications

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

#### ID Cards

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

#### Cancellation limitation

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

#### Plan administration

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

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

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

#### *For all other individual dental and vision plans*

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

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

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

## APPENDIX II:

### Benefit summaries for Veterans:

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

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

## APPENDIX III: Paper Application Information

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

All paper applications for Individual plans include:

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

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

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