Individual Dental

MIB HEALTH INSURANCE

Rates listed below are just estimates and can change based on age.

DELTA DENTAL

Family Size	Ultimate Plan	Elite Plan	Enhanced Plan	Clear Plan	Basic Plan
Single	$78.00	$63.00	$54.06	$44.50	$31.24
Single + Spouse	$165.33	$126.00	$108.10	$94.00	$62.44
Single + Child	$147.00	$115.00	$89.04	$82.00	$62.44
Single + Children	$209.00	$173.00	$141.40	$115.00	$106.22
Family + Child	$232.00	$172.00	$143.10	$131.00	$92.46
Family + Children	$280.00	$230.00	$195.44	$156.00	$137.44

Dentist Search

Dentist Search: CLICK HERE (https://www.deltadentalcoversme.com/s/dentistsearch)
Apply Online: CLICK HERE (https://my.deltadentalcoversme.com/sales/start?zipCode=54949&atch_agency=1728457110

Apply

Broker Name: Select Mike Dietz

HUMANA

Humana Individual Dental Plans			
Family Size	Complete Dental	Loyalty Plus	Bright Plus
Single	$50.99	$39.99	$32.93
Single & Spouse	$92.99	$76.98	$65.86
Single 1 Child	$92.99	$76.98	$70.80
Single +Children	$125.99	$114.97	$108.67
Family 1 Child	$125.99	$114.97	$103.73
Family + Children	$214.99	$190.95	$179.47

Dentist Search: CLICK HERE (https://idv.humana.com/humanaonenetwork/search-providers-generic.aspx)
Apply Online: CLICK HERE (https://www.humana.com/agent/health-insurance-Agents/AOALanding?SANID=1303798&isMarketpointAgent=false)

Dentist Search

Apply

DELTA DENTAL®

Comparison of Key Benefits Under Delta Dental Individual and Family℠ Plans

Plan benefit	Ultimate Plan The percent you pay after 1, 2, and 3+ years of coverage with us*			Elite Plan The percent you pay after your deductible (where required)*	Enhanced Plan The percent you pay after your deductible (where required)*	Clear Plan℠ You pay the fixed dollar amount shown below when covered services are provided by a network dentist*	Basic Plan The percent you pay after your office visit copay (no deductible)*
	Year 1	Year 2	Year 3				
Office Visit Copay	None	None	None	None	None	None	$15
Cleanings	0%	0%	0%	0%	0%	$65	0%
Exams	0%	0%	0%	0%	0%	included in cleaning	0%
Bitewing X-rays	0%	0%	0%	0%	0%	included in cleaning	0%
Topical Fluoride	0%	0%	0%	0%	0%	included in cleaning	50%
Fillings	60%	40%	20%	20%	50%	$115	50%[2]
Root Canals	60%	40%	20%	20%[1]	50%[1]	$535	N/A
Non-Surgical Extractions	60%	40%	20%	20%[1]	50%[1]	$115	50%[2]
Crowns	70%	60%	50%	50%[1]	50%[1]	$740	N/A
Implants	70%	60%	50%	50%[1]	50%[1]	$2,600	N/A
Veneers	70%	60%	50%	N/A	N/A	N/A	N/A
Teeth Whitening	70%	60%	50%	N/A	N/A	N/A	N/A
Orthodontics	N/A	N/A	N/A	50%[1] $2,000 lifetime maximum	N/A	N/A	N/A
Dollar Maximum (per person per policy year)	$750	$1,500	None	$2,000	$1,000	None	$1,000
Deductible (per person per policy year, unless otherwise noted)	$50 (lifetime) (does not apply to routine procedures like cleanings, exams, X-rays, and topical fluoride)			$50 (does not apply to routine procedures like cleanings, exams, X-rays, and topical fluoride)	$50 (does not apply to routine procedures like cleanings, exams, X-rays, and topical fluoride)	None	None
Annual Contract Required	Yes			Yes	Yes	Yes	Yes

[1]A 12-month waiting period may apply
[2]A 6-month waiting period may apply
*For the Ultimate, Elite, Enhanced, and Basic Plans, your out-of-pocket costs are likely to be greater when covered services are provided by a non-network dentist. The Clear Plan does not cover services received from non-network dentists.

Delta Dental of Wisconsin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

WISCONSIN

Humana Individual Dental plans

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

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

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

Jump to:
→ Rate Sheet Links

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Additional dental plan options