

About your plan

This individual Humana Extend 2500 dental and vision plan is designed for people who are looking to combine their coverages into a single plan while maximizing their benefits. This plan offers access to a nationwide network of providers who specialize in routine dental and vision services. Coverage includes preventive, basic, and major dental services, in addition to vision services.

Who can enroll in this plan – Anyone can enroll in this plan.

How your plan works

- Preventive, Basic, and Major dental coverage.
- Dental implant coverage.
- Preventive dental services are covered at 100% for both in and out of network after deductible (deductible waived for in-network preventive services). Coinsurance for basic and major dental services after deductible.
- Teeth whitening coverage.
- Vision coverage.

Dental coverage

Good oral health means more than an attractive smile. Research shows that oral health, preventive care and regular visits to the dentist are integral to overall health.¹ Members can maximize benefits by choosing one of the more than 143,000 dentists and specialists* in our nationwide network. Visit [Humana.com/FindCare](https://www.humana.com/FindCare) to find a participating dentist.

Calendar year deductible

This is the dollar amount you pay for covered services each calendar year before the plan pays

Individual

\$75 per person
(deductible waived for in-network preventive services)

Family

\$75 per person
(deductible waived for in-network preventive services)

Annual & lifetime maximums

This is the maximum amount that the plan will pay for covered services

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|--|---|
| • Dental Preventive, Basic & Major annual maximum | \$2,500 per person (for all covered services combined, including dental implants) |
| • Dental Implant annual maximum | \$1,000 per person |
| • Dental Implant lifetime maximum | \$2,000 per person |

Dental care services

	In-network coverage	Out-of-network coverage [†]
Preventive services (no waiting period) <ul style="list-style-type: none"> Routine periodic oral examinations (limit two every calendar year) Limited oral examination (limit one every calendar year) Comprehensive oral examination (limit one every three years) Comprehensive periodontal evaluation (limit one every three years) Bitewing X-rays (limit one set of two films every calendar year for ages 10 and younger, and limit one set of four films every calendar year for ages 11 and older) Panoramic film (limit one every five years) Routine cleanings – prophylaxis (limit two every calendar year) Topical fluoride (limit two every calendar year) Sealants (limit of once per tooth per lifetime) 	100% no deductible	100% after deductible
Basic services (no waiting period) <ul style="list-style-type: none"> Simple extractions and root removal Restorations – fillings (composites covered on front teeth only²) Space maintainers (age 14 and younger for primary teeth only) Anesthesia Palliative treatment of dental pain – per visit 	80% after deductible	80% after deductible
Major services (no waiting period) <ul style="list-style-type: none"> Endodontics – root canals (limit one per tooth per lifetime) Complete dentures (limit one every five years) Removable partial dentures (limit one every five years) Denture repair and adjustments (if more than six months after initial placement) Crowns, inlays and onlays (limit once per tooth every five years) Surgical extractions Periodontal maintenance (limit two every calendar year) Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (limit one every calendar year, reduces the limit for cleaning (prophylaxis) services) 	50% after deductible	50% after deductible

Dental care services (continued)

	In-network coverage	Out-of-network coverage†
Major services (continued) (no waiting period) <ul style="list-style-type: none"> Periodontal scaling and root planing (limit one per quadrant every three years) Dental implant – surgical placement (limit one per tooth per five years, subject to review, clinical necessity and frequencies) <p><i>Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.</i></p>	50% after deductible	50% after deductible
Teeth whitening (no waiting period) <ul style="list-style-type: none"> External bleaching – per arch – performed in office 	\$100 allowance, does not apply to deductible or annual dental maximum	

* Based on Humana network data, last accessed November 2025.

† Out-of-network dental providers have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more than what the plan pays. Members are responsible for this difference between Humana’s reimbursement and the out-of-network provider’s charges. This is known as balance billing. Benefits received are subject to any benefit maximums, limitations and/or exclusions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, the member may have to pay upfront and submit a request for reimbursement.

Important to know: This plan has a minimum one-year initial contract period. If further clarification regarding coverage and benefits is needed, please ask your dentist for a pretreatment estimate.

Footnotes

1. “Gum Diseases and other Diseases,” American Academy of Periodontology, last accessed Oct. 6, 2025, <https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/>

2. Composite (white) fillings are only covered on anterior (front) teeth. An alternate benefit is allowed for composite fillings on posterior (back) teeth where the plan will cover the cost of an amalgam (silver) filling and the member is responsible for any cost over the covered amount.

Vision coverage

Having your eyes checked every year can help detect vision-related complications, including glaucoma, cataracts, and diabetic retinopathy—the leading cause of blindness among adults³ and the most common eye complication in diabetic patients⁴.

Members have access to America’s largest vision network[‡], with optometrists and ophthalmologists at more than 214,000 access points^{**}, including both independent and national retail locations such as LensCrafters®, Pearle Vision®, and Target Optical®. Visit [Humana.com/FindCare](https://www.humana.com/FindCare) to find a provider near you.

Vision care services

	In-network	Out-of-network
Exam (one every 12 months from the last date of service) <ul style="list-style-type: none"> Routine exam Retinal imaging 	\$10 copay \$39	\$30 allowance Not covered
Contact lens exam options (one every 12 months from the last date of service) <ul style="list-style-type: none"> Standard contact lens fit and follow-up Premium contact lens fit and follow-up 	\$40 copay 10% off retail price	Not covered Not covered
Frames (one every 24 months from the last date of service) <ul style="list-style-type: none"> Frames 	\$0 copay \$100 allowance (20% off balance over \$100)	\$50 allowance
Lens options (one every 12 months from the last date of service) <ul style="list-style-type: none"> Single vision Bifocal Trifocal Lenticular Progressive lenses – standard (add-on to bifocal) <ul style="list-style-type: none"> Progressive lenses – tier 1 Progressive lenses – tier 2 Progressive lenses – tier 3 Progressive lenses – tier 4^{††} Anti-reflective coating – standard <ul style="list-style-type: none"> Anti-reflective coating – premium tier 1 Anti-reflective coating – premium tier 2 Anti-reflective coating – premium tier 3 Photochromic – non-glass 	\$25 copay \$25 copay \$25 copay \$10 copay \$50 copay \$110 \$120 \$135 \$90; 20% off retail price less \$120 allowance \$45 \$57 \$68 20% off retail price \$75	\$25 allowance \$40 allowance \$55 allowance \$100 allowance \$40 allowance Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered

Vision care services (continued)

	In-network	Out-of-network
Lens options (continued) (one every 12 months from the last date of service)		
• UV Coating	\$15	Not covered
• Tint (solid and gradient)	\$15	Not covered
• Standard scratch coating – plastic	\$15	Not covered
• Standard polycarbonate – age 19 and older	\$40	Not covered
• Standard polycarbonate – age 18 and younger	\$40	Not covered
• Other add-ons and services	20% off retail price	Not covered
Contact lenses (one every 12 months from the last date of service)		
• Conventional	\$100 allowance (15% off balance over \$100)	\$80 allowance
• Disposable	\$100 allowance	\$80 allowance
• Medically Necessary	\$0 copay	\$200 allowance
Laser vision correction		
• Lasik or photorefractive keratectomy (PRK) from U.S. Laser Network	15% off retail price or 5% off promotional price	Not covered
Special offers		
• Other	20% off retail price on items not covered by plan ^{‡‡}	Not covered

‡ Based on the EyeMed Insight network and analysis of competitors' largest networks via competitor data, 2023.

** Based on Humana network data, last accessed October 2025.

†† Tier 4 progressive lens calculation: Multiply retail price by 80%, subtract the \$120 allowance, and add \$90.

‡‡ Get 40% off a complete second pair of prescription glasses from participating in-network providers. Simply ask your provider, then choose your favorite frames and lenses.

Special offers and discounts are not insurance. These are only available from participating in-network providers and are subject to change without notice.

Additional details:

Member may receive a 20% discount on items not covered by the plan at in-network locations. Discount does not apply to provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see our online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

Members may receive a 15% discount off retail price or may receive 5% off any promotional price for Lasik or photorefractive keratectomy (PRK) laser correction procedures. Lasik or PRK correction procedures are provided by the U.S. Laser Network, owned by LCA Vision. Please note that since Lasik and PRK vision correction are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your immediate location, so members should first call **844-608-2020** for the nearest facility and to receive authorization for the discount.

You also have access to exclusive, members-only special offers and discounts to use above and beyond your vision benefit; they are not part of the insurance plan. Please contact your provider or see the online provider locator to determine which participating providers have agreed to the discounted rate. New offers are added often, so have a look before scheduling your next eye exam.

The covered person is responsible for payment of any amounts in excess of the allowance. Allowances provide no remaining balance for future use within the same Benefit Frequency.

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 may be available.

Footnotes

3. "About Common Eye Disorders and Diseases," Centers for Disease Control and Prevention, last accessed Oct. 6, 2025, <https://www.cdc.gov/vision-health/about-eye-disorders>

4. "Diabetic Eye Disease Resources," National Eye Institute, last accessed Oct. 6, 2025, <https://www.nei.nih.gov/learn-about-eye-health/outreach-resources/diabetic-eye-disease-resources>



Limitations and exclusions

This is an outline of the limitations and exclusions for this Humana individual dental and vision plan. Consult the policy for a complete list of limitations and exclusions. In addition to any limitations and exclusions listed in “Schedule of Policy Benefits” or “Definition” sections, this policy does not provide benefits for the following:

1. Any expenses incurred while a covered person qualifies for any Worker’s Compensation or occupational disease act or law, whether or not the covered person applied for coverage.
2. Services:
 - a. That are free or that a covered person would not be required to pay for if they did not have this insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
 - b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - c. Furnished by any United States government-owned or operated hospital/institution/agency.
3. Any loss caused or contributed by:
 - a. War or any act of war, whether declared or not;
 - b. Taking part in a riot;
 - c. Commission of or an attempt to commit a criminal act;
 - d. Engaging in an illegal profession or occupation;
 - e. Any act of armed conflict; or
 - f. Any conflict involving armed forces of any authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the provider.
6. Services we consider cosmetic dentistry unless it is required as a result of an accidental injury sustained while the covered person is covered under this policy.
7. Charges for:
 - a. Any type of implant and all related services, including crowns or the prosthetic device attached to it, unless otherwise included as a covered service in the "Schedule of Policy Benefits";
 - b. Precision or semi-precision attachments;
 - c. Overdentures and any endodontic treatment associated with overdentures;
 - d. Other customized attachments;
 - e. 3D imaging;
 - f. Temporary and interim dental services;
 - g. Separate charges for materials or use of equipment, such as lasers; or
 - h. Separate charges for treatment rendered in a clinic, dental or medical facility owned, operated, sponsored or maintained by either (i) the employer or any covered person; or (ii) by an employee of any covered person.
8. Any service related to:
 - a. Altering vertical dimension of teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
 - e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for dental treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.

Limitations and exclusions (continued)

13. Services not specifically listed in the “Schedule of Policy Benefits” section.
14. Services shown as “Not Covered” in the “Schedule of Policy Benefits” section.
15. Services that we determine:
 - a. Are not eligible for benefits based upon clinical review;
 - b. Do not have uniform professional acceptance; or
 - c. Are deemed to be experimental or investigational in nature.
16. Orthodontic services.
17. Any expense incurred before the covered person’s effective date or after the date the covered person’s coverage under this policy terminates.
18. Services provided by someone who ordinarily lives in the covered person’s home or is a family member.
19. Charges exceeding the reimbursement limit for the service.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Repair or replacement of orthodontic appliances.
22. Elective removal of non-pathologic impacted teeth.
23. Service for orthognathic surgery.
24. Services generally considered medical or covered by a medical plan.
25. Services for destruction of lesions by any method.
26. Services for tooth transplantation.
27. Services for removal of a foreign body from the oral tissue or bone.
28. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
29. Any separate fees for pre and post-operative care.
30. Replacement of restorations (fillings) placed less than two years ago.
31. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
32. Orthoptic or vision training.
33. Subnormal vision aids and associated testing.
34. Aniseikonic lenses.
35. Any vision service that we determine is not visually necessary or appropriate.
36. Plano lenses.
37. Medical or surgical treatment of eye, eyes, or supporting structures.
38. Replacement of lenses or frames furnished under this policy which are lost or broken, unless otherwise available under the policy.
39. Any vision examination or material required by an employer as a condition of employment.
40. Non-prescription sunglasses.
41. Two pair of glasses in lieu of bifocals.
42. Services or materials provided by any other group benefit plans providing vision care.
43. Certain name brands when manufacturer imposes no discount.
44. Solutions and/or cleaning products for glasses or contact lenses.
45. Pathological vision treatment.
46. Non-prescription vision items.

Limitations and exclusions (continued)

47. Costs associated with securing vision materials.
48. Pre- and Post-operative vision services.
49. Orthokeratology.
50. Routine maintenance of vision materials.
51. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the policy.
52. Artistically painted lenses.

Insured by Humana Insurance Company.

Policy number: NM-72032

Applications are subject to approval. This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control. Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.

EyeMed (the Vendor) is a third-party vendor. Humana's contract with the Vendor does not eliminate a member of any obligations under the policy or change the terms of the policy. Participation in a Vendor's program is voluntary. All representations and warranties contained in this marketing material are made solely by the Vendor, not Humana. Humana and the Vendor, including each party's respective affiliates and subsidiaries, are independent, non-affiliated entities. Humana, its parent and affiliates are not liable to members for the negligent provision of services by the Vendor.

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