Humana Extend 2500

New York

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 (waiting periods may apply).
- 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** 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	Family
	$75 per person (deductible waived for in-network preventive services)	$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

• **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

Humana.

Dental care services	In-network coverage	Out-of-network coverage[†]
Preventive services (no waiting period) • 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, age 14 and younger for primary teeth only)	100% no deductible	100% after deductible
Basic services (90 day waiting period) • Simple extractions and root removal • Restorations – fillings (limit one per tooth per two years, composites covered on front teeth only[2]) • 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 (12 month waiting period) • 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) – *no waiting period for this service* • 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) – *no waiting period for this service*	50% after deductible	50% after deductible

Dental care services (continued)	In-network coverage	Out-of-network coverage†
Major services (continued) (12 month waiting period) • Periodontal scaling and root planing (limit one per quadrant every three years) – *no waiting period for this service* • **Dental implant** – surgical placement (limit one per tooth per five years, subject to review, clinical necessity and frequencies) *Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.*	50% after deductible	50% after deductible
Teeth whitening (no waiting period) • 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: 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 adults[3] and the most common eye complication in diabetic patients[4].

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** 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)		
• Routine exam	$10 copay	$30 allowance
• Retinal imaging	$39	Not covered
Contact lens exam options (one every 12 months from the last date of service)		
• Standard contact lens fit and follow-up	$40 copay	Not covered
• Premium contact lens fit and follow-up	10% off retail price	Not covered
Frames (one every 24 months from the last date of service)		
• Frames	$0 copay $100 allowance (20% off balance over $100)	$50 allowance
Lens options (one every 12 months from the last date of service)		
• Single vision	$25 copay	$25 allowance
• Bifocal	$25 copay	$40 allowance
• Trifocal	$25 copay	$55 allowance
• Lenticular	$25 copay	Not covered
• Progressive lenses – standard (add-on to bifocal)	$50 copay	$40 allowance
• Progressive lenses – tier 1	$110	Not covered
• Progressive lenses – tier 2	$120	Not covered
• Progressive lenses – tier 3	$135	Not covered
• Progressive lenses – tier 4[††]	$90; 20% off retail price less $120 allowance	Not covered
• Anti-reflective coating – standard	$45	Not covered
• Anti-reflective coating – premium tier 1	$57	Not covered
• Anti-reflective coating – premium tier 2	$68	Not covered
• Anti-reflective coating – premium tier 3	20% off retail price	Not covered
• Photochromic – non-glass	$75	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 (In lieu of 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.

‡‡ Plan allows the member to receive either contacts or lens services.

*** 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



Humana.

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. Cosmetic Services

   We do not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be medically necessary.

2. Experimental or Investigational Treatment

   We do not cover any health care service, procedure, treatment, or device that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under this policy for non-investigational treatments. See the General Provisions, Appeal Rights section of this policy for a further explanation of your appeal rights.

3. Felony Participation

   We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.

4. Government Facility

   We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

5. Medical Services

   We do not cover medical services or dental services that are medical in nature, including any hospital charges or prescription drug charges.

6. Medically Necessary

   In general, we will not cover any dental service, procedure, treatment, test or device that we determine is not medically necessary. If an external appeal agent certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise covered under the terms of this policy.

7. Medicare or Other Governmental Program

   We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

8. Military Service

   We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

Limitations and exclusions (continued)

9. Services Not Listed

   We do not cover services that are not listed in this policy as being covered.

10. Services Provided by an Immediate Family Member

    We do not cover services performed by a member of the covered person's immediate family. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

11. Services Separately Billed by Hospital Employees

    We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

12. Services with No Charge

    We do not cover services for which no charge is normally made.

13. War

    We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

14. Worker's Compensation

    We do not cover services if benefits for such services are provided under any state or federal workers' compensation, employers' liability or occupational disease law.

Insured by Humana Insurance Company of New York.

Policy number: NY-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.

Links to various other websites from this site are provided for your convenience only and do not constitute or imply endorsement by Humana, Inc. or its subsidiaries of these sites, any products, views, or services described on these sites, or of any other material contained therein. Humana disclaims responsibility for their content and accuracy.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

Humana.