# Humana Extend 1250

Pennsylvania

## About your plan

This individual Humana Extend 1250 dental, vision, and hearing 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, vision, and hearing services. Coverage includes preventive, basic, and major dental services, in addition to vision and hearing services.

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

## How your plan works

- Preventive, Basic, and Major dental coverage (elimination periods* may apply).
- Preventive dental services are covered at 100% for both in and out of network after deductible. Coinsurance for basic and major dental services after deductible.
- Teeth whitening coverage.
- Vision and hearing 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**<br>This is the dollar amount you pay for covered services each calendar year before the plan pays | Individual | Family |
|---|---|---|
| | $75 per person | $75 per person |
| **Annual maximum**<br>This is the maximum amount that the plan will pay in a calendar year for covered services | $1,250 per person | |

| **Dental care services** | In-network coverage | Out-of-network coverage‡ |
|---|---|---|
| **Preventive services** (no elimination period*)<br>• Routine periodic oral examinations (limit two every calendar year)<br>• Limited oral examination (limit one every calendar year)<br>• Comprehensive oral examination (limit one every three years)<br>• Comprehensive periodontal evaluation (limit one every three years)<br>• 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) | 100% after deductible | 100% after deductible |

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| Dental care services (continued) | In-network coverage | Out-of-network coverage‡ |
|---|---|---|
| **Preventive services (continued)** (no elimination period*)<br>• Panoramic film (limit one every five years)<br>• Routine cleanings – prophylaxis (limit two every calendar year)<br>• Topical fluoride (limit two every calendar year)<br>• Sealants (limit of once per tooth per lifetime, age 14 and younger for primary teeth only) | 100% after deductible | 100% after deductible |
| **Basic services** (30 day elimination period*)<br>• Simple extractions and root removal<br>• Restorations – fillings (limit one per tooth per two years, composite covered on front teeth only[2])<br>• Space maintainers (age 14 and younger for primary teeth only)<br>• Anesthesia<br>• Palliative treatment of dental pain – per visit | 60% after deductible | 60% after deductible |
| **Major services** (12 month elimination period*)<br>• Endodontics – root canals (limit one per tooth per lifetime)<br>• Complete dentures (limit one every five years)<br>• Removable partial dentures (limit one every five years)<br>• Denture repair and adjustments (if more than six months after initial placement)<br>• Crowns, inlays and onlays (limit once per tooth every five years)<br>• Surgical extractions<br>• Periodontal maintenance (limit two every calendar year) – *no elimination period* for this service*<br>• Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (one every calendar year, reduces the limit for cleaning (prophylaxis) services) – *no elimination period* for this service*<br>• Periodontal scaling and root planing (limit one per quadrant every three years) – *no elimination period* for this service*<br>*Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.* | 30% after deductible | 30% after deductible |
| **Teeth whitening** (no elimination period*)<br>• External bleaching – per arch – performed in office | $100 allowance, does not apply to deductible or annual dental maximum | |

* You may sometimes see elimination period referred to as waiting period.

† 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.

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**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 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)<br>• Routine exam only | $0 copay | $0 copay |

** 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.

**Additional plan discounts:**

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.

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




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## Hearing coverage

You must see a TruHearing® provider to use this benefit. Call **855-241-6293 (TTY: 711)** to schedule an appointment. You will have access to over 8,850 provider locations in the TruHearing network‡‡. Visit Truhearing.com/humanaextend/ for more information.

| Covered item or service | Description/frequency | Member cost share (In-network only) |
|---|---|---|
| **Hearing exam** | One routine hearing exam per calendar year | $0 copay |
| **TruHearing hearing aid options** | | |
| Advanced level hearing aid | One TruHearing-branded hearing aid per ear per calendar year (various styles and colors; disposable-battery-powered options only) | $699 copay per ear |
| Premium level hearing aid | One TruHearing-branded hearing aid per ear per calendar year (various styles and colors; disposable-battery-powered and rechargeable*** options available) | $999 copay per ear***<br>*** $50 additional cost per aid for rechargeable aids |
| **TruHearing hearing aid purchase includes** | | |
| Follow-up visits | Provider visits covered for the first 12 months after initial hearing aid fitting | $0 |
| Batteries | 80 batteries included with initial purchase of each non-rechargeable hearing aid | $0 |
| 60-day trial period (additional charges may apply if hearing aid is exchanged for a more expensive hearing aid) | Hearing aid(s) may be returned within 60 days of initial fitting for a full refund of cost of hearing aid(s) | $0 |
| Three-year extended warranty or replacement of hearing aid(s) | Repair or replacement of hearing aid as necessary due to manufacturer defect, loss or irreparable damage (manufacturer and reprogramming fees may apply) | Costs associated with loss & damage warranty claims |

Benefit does not provide and excludes coverage for the following[5]:

- Ear molds.
- Hearing aid accessories.
- Additional provider visits to service hearing aids (except as included with initial hearing aid purchase).
- Additional batteries beyond the free batteries included with a non-rechargeable hearing aid purchase.
- Hearing aids of any kind that are not TruHearing-branded hearing aids.
- Costs associated with loss & damage warranty claims.

‡‡ MarkeTrak 10

**Footnotes**

5. Costs for excluded items are the responsibility of the member and not covered by the hearing benefit.

## Limitations and exclusions

This is an outline of the limitations and exclusions for this Humana individual dental, vision, and hearing plan. It is designed for convenient reference. 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 arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which coverage was available under any Workers Compensation or Occupational Disease Act or Law.
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 offer a favorable prognosis;
    c. Do not have uniform professional acceptance; or
    d. 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. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Service for orthognathic surgery.
25. Services generally considered medical or covered by a medical plan.
26. Services for destruction of lesions by any method.
27. Services for tooth transplantation.
28. Services for removal of a foreign body from the oral tissue or bone.
29. Services for reconstruction of surgical, traumatic or congenital defects of the facial bones unless dental related.
30. Any separate fees for pre and post-operative care.
31. Replacement of restorations (fillings) placed less than two years ago.
32. We will not cover the replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
33. Orthoptic or vision training.
34. Subnormal vision aids and associated testing.
35. Aniseikonic lenses.
36. Any vision service that we determine is not visually necessary or appropriate.
37. Plano lenses.
38. Medical or surgical treatment of eye, eyes, or supporting structures.
39. Replacement of lenses or frames furnished under this policy which are lost or broken, unless otherwise available under the policy.
40. Any vision examination or material required by an employer as a condition of employment.
41. Non-prescription sunglasses.
42. Two pair of glasses in lieu of bifocals.
43. Services or materials provided by any other group benefit plans providing vision care.
44. Certain name brands when manufacturer imposes no discount.
45. Solutions and/or cleaning products for glasses or contact lenses.
46. Pathological vision treatment.
47. Non-prescription vision items.

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

Insured by Humana Insurance Company.

Policy number: PA-72032 9/24

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 and TruHearing (the Vendors) are third-party vendors. Humana's contract with the Vendors does not eliminate a member of any obligations under the policy or change the terms of the policy. Participation in a Vendors' program is voluntary. All representations and warranties contained in this marketing material are made solely by the Vendors, not Humana. Humana and the Vendors, 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 Vendors.

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