Humana Extend 5000

Pennsylvania

About your plan

This individual Humana Extend 5000 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).
- 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 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 135,000 dentists and specialists† in our nationwide network. Visit **Humana.com/Find-Care** to find a participating dentist.

Calendar year deductible	Individual	Family
This is the dollar amount you pay for covered services each calendar year before the plan pays	$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**	$5,000 per person (for all covered services combined, including dental implants)
• **Dental Implant annual maximum**	$2,000 per person
• **Dental Implant lifetime maximum**	$4,000 per person

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Dental care services	In-network coverage	Out-of-network coverage‡
Preventive services (no elimination 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) • 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 (30 day elimination period* applies – policyholders who provide proof of prior comparable dental coverage may be exempt from this elimination period*)[2] • Simple extractions and root removal • Restorations – fillings (limit one per tooth per two years, composites covered on front teeth only[3]) • 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 (6 month elimination period* applies – policyholders who provide proof of prior comparable dental coverage may be exempt from this elimination period*)[2] • 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 elimination period* for this service* • 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*	Year one 50% after deductible Year two and any subsequent years 60% after deductible	Year one 50% after deductible Year two and any subsequent years 60% after deductible

Dental care services (continued)	In-network coverage	Out-of-network coverage‡
Major services (continued) (6 month elimination period* applies – policyholders who provide proof of prior comparable dental coverage may be exempt from this elimination period*)[2]		
• Periodontal scaling and root planing (limit one per quadrant every three years) – *no elimination period* for this service* *Note: Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered.*	Year one 50% after deductible Year two and any subsequent years 60% after deductible	Year one 50% after deductible Year two and any subsequent years 60% after deductible
Additional major services (6 month elimination period* applies for all implant services and cannot be waived)		
• Dental implant – surgical placement (One per tooth per five years, subject to review, clinical necessity and frequencies)	Year one 50% after deductible Year two and any subsequent years 60% after deductible	Year one 50% after deductible Year two and any subsequent years 60% after deductible
Teeth whitening (no elimination period*)		
• External bleaching – per arch – performed in office	$200 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 October 2024.

‡ Out-of-network dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network. Elimination periods* and other limitations may apply; please see your policy for coverage details.

Important to know: Dental and vision plans, excluding Dental Savings Plus, may have 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. 11, 2024, https://www.perio.org/for-patients/gum-disease-information/gum-disease-and-other-diseases/

2. Policy-holders 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.

3. 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[4] and the most common eye complication in diabetic patients[5].

Members have access to one of the largest vision networks in the United States**, 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®. Visit **Humana.com/Find-Care** 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	$0 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	$150 allowance (20% off balance over $150)	$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	$90	Not covered
◦ Progressive lenses – tier 2	$100	Not covered
◦ Progressive lenses – tier 3	$110	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
• UV Coating	$15	Not covered

Vision care services (continued)	In-network	Out-of-network
Lens options (continued) (one every 12 months from the last date of service)		
• 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	$150 allowance (15% off balance over $150)	$80 allowance
• Disposable	$150 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 Network360 data, 2021.

†† Based on Humana network data, last accessed November 2024.

‡‡ 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 are easily accessible from the plan's website and can be used above and beyond your vision benefit; they are not part of the insurance plan. New offers are added often, so have a look before scheduling your next eye exam.

Allowance means the maximum amount we will pay for a covered service as shown in the "Schedule of Policy Benefits". The covered person is responsible for payment of any amounts in excess of the allowance. In the event the dollar amount of the covered service is less than the allowance amount shown in the "Schedule of Policy Benefits", then we will only pay up to the actual dollar amount of the covered service.

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

4. "About Common Eye Disorders and Diseases," Centers for Disease Control and Prevention, last accessed Oct. 11, 2024, https://www.cdc.gov/vision-health/about-eye-disorders

5. "Diabetic Eye Disease Resources," National Eye Institute, last accessed Oct. 11, 2024, https://www.nei.nih.gov/learn-about-eye-health/outreach-resources/diabetic-eye-disease-resources

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/.com 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**** **** $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[6]:

- 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

6. 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.
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.

Limitations and exclusions (continued)

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.

Limitations and exclusions (continued)

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 Vendor's 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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