Humana

Humana Complete Gold

[Group Name]	Plan 703	Description of Benefits
This Description of Benefits table contains the copayments, coinsurances and deductibles of the benefits described in the Certificate of Benefits and is part of the Certificate. For details of benefits, limitations and exclusions of services listed in this table, please refer to the Certificate of Benefits.		
Maximum Out-Of-Pocket (MOOP)		
MOOP Network Provider	Individual: $6,350	Familiar: $12,700
MOOP Out of Network Provider	Individual: $19,050	Familiar: $38,100

Essential Benefits

Ambulatory Services

Service	Benefit
Generalists	Unlimited, less $10 office visit copayment.
Specialists	Unlimited, less $15 office visit copayment.
Sub-specialists	Unlimited, less $15 office visit copayment.
Chiropractic Services	Covered, one (1) initial visit, one (1) follow-up visit, less $15 visit copayment and up to twenty (20) manipulations per insured, per policy year. Physical therapies, unlimited, less $10 copayment.
Nutritionist	Six (6) Nutritionist consultations per insured per policy year, less $15 office visit copayment.
Laboratories and X-rays s (reproduction) and genetic tests	Covered, including the reproduction, unlimited, less 30% of coinsurance. Genetic tests require pre-authorization, less 30% of coinsurance.
Specialized tests	Covered, unlimited, less 30% coinsurance.
Electrocardiogram	Unlimited, less 30% coinsurance.
Ultrasound	Unlimited, less 30% coinsurance.
Computerized Tomography (CT)	One (1) test, anatomical region, per policy year, pre-authorization required. Less 30% coinsurance.
Positron Emission Tomography (PET)	One (1) test per policy year, pre-authorization required. Less 30% coinsurance.
Electroencephalogram	Unlimited, less 30% coinsurance.
Electromyogram	Unlimited, less 30% coinsurance.
Magnetic Resonance (including MRI and MRA)	MRI two (2) per anatomical region per insured per policy; MRA unlimited. Less 30% coinsurance. Pre-authorization required.
Polysomnography	One (1) sleep study or polysomnography covered per insured, per policy year, pre-authorization required. Less 30% coinsurance.
Nuclear medicine tests	Unlimited, less 30% coinsurance.
Respiratory Therapy	Unlimited, less $10 office visit copayment.
Physical Therapy	Twenty (20) therapy sessions, per policy year, including rehabilitation and habilitation. Less $10 copayment.
Speech Therapy and Occupational Therapy	Twenty (20) speech/language and/or occupational therapies combined per insured per policy year, less $15 copayment. Unlimited speech/language and occupational therapies for autism according to Law No. 220 of September 4, 2012, less $15 copayment.

Outpatient surgery	Covered at ambulatory surgery facilities, less $75 facility copayment.
Endoscopies, diagnostic and therapeutic	Unlimited, less $15 office copayment or less $75 facility copayment.
Lithotripsy	Unlimited, less $75 ambulatory facility copayment per rendered service. Pre-authorization required.
Vasectomy	Vasectomy at physician's office, less $15 office visit copayment, less $75 ambulatory facility.
Dialysis and hemodialysis	Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications related directly to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, less $75 ambulatory facility or in case of admission apply $150 copayment.
Allergy tests	Including allergenic and biological extracts, drugs, patches, and provocative tests, up to a maximum of fifty (50) tests per insured per policy year, less 30% coinsurance.
Intra-articular injections	Unlimited, less $15 office copayment or less $75 facility copayment.
Audiometry and tympanometry tests	Covered, when ordered by a physician, one (1) of each test per insured, per policy year. Less 30% of coinsurance.
Orthognathic Surgery (mandibular or maxillary osteotomy - Le Fort)	Covered, less $75 ambulatory facility. Pre-authorization required. Expenses for implants related to orthognathic surgery are excluded.
Diagnostic tests and treatments associated with hemophilia	Covered, less 30% coinsurance.
Eye refraction test	One (1) eye refraction test, per insured, per policy year, less $15 office visit copayment.
Ophthalmic Diagnostic Tests	Covered, unlimited, less $15 office visit copayment.
Naturopathic Doctor visit	Unlimited visits and consultations, covered according to Law 210 dated on December 14, 2007, less $15 office visit copayment.
Podiatrist	Podiatry visits: Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less $15 office visit copayment or $75 ambulatory facility.
Cervical Cryosurgery	Covered, less $15 office visit copayment.
Nerve conduction velocity test	Two (2) tests covered per insured, per policy year, per policy year, less 30% coinsurance.
Anesthesia and hospitalization for dental services	Covered, when medically necessary. Pre-authorization required.

Preventive Services

Annual preventive services are **covered at 100%** (without copayment or coinsurance) when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), The Health Resources and Services Administration, and the Puerto Rico Department of Health. For more information and updates on preventive services, visit: https//www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
Some services covered at 100%:

- Routine physical examination, including height, weight, and body mass index (BMI), for children and adults.
- Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults 40 years of age and older. The risks and benefits of these methods vary.
- Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).
    - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella
    - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus
- Pap Smear
- Prostatic Specific Antigen test (PSA) for men
- Women's contraceptives and contraception counseling. All women's contraceptive methods approved by the Federal Drug Administration (FDA) by prescription are covered, including counseling, placement and removal of uterine devices, administration of medication and sterilization
- Support for breastfeeding with guidance and counseling and the necessary supplies, including the breast pump with prescription.

Other Preventive Services:

- Screening for Human Immunodeficiency Virus (HIV) covered at 100% (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016.
- Breast cancer screening test covered at 100%, according to Law 10 of January 3, 2020.

Refer to the Certificate of Benefits for details of the Preventive Services.

Hospitalization services

Benefits includes in per diem	Semi-private room or similar facility up to a maximum of 365 days; Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU); Operating, recovery, and maternity rooms; Oxygen and its administration; Laboratory and radiology; Drugs prescribed by physician during hospital stay that are included in the per diem; Disposable supplies; Special and regular diets; Regular hospital nursing service, less $150 admission copayment.
Partial hospitalization	Covered, including for mental health, less $75 copayment.
Hyper alimentation Services	Covered as part of the hospital admission copayment.
Surgical Procedures	Covered as part of the hospital admission copayment.
Anesthetic agents and their administration	Covered as part of the hospital admission copayment.
Ultrasounds and specialized tests	Covered, as medically necessary, as part of the hospital admission copayment.
Computerized Tomography (CT)	Covered, as medically necessary, as part of the hospital admission copayment.

Magnetic Resonance (MRI & MRA)	Covered, as medically necessary, as part of the hospital admission copayment.
Nuclear medicine studies and digital angiography	Covered, as medically necessary, as part of the hospital admission copayment.
Blood and plasma	Covered as part of the hospital admission copayment.
Respiratory Therapy	Covered as part of the hospital admission copayment.
Physical Therapy	Covered, maximum of forty (40) therapy sessions per insured, per hospital stay, as part of the hospital admission copayment.
Dialysis and hemodialysis	Covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed. Covered, as part of the hospital admission copayment.
Morbid obesity	Treatment and services for morbid obesity as medically necessary and authorized by Humana. One (1) bariatric surgery per lifetime. Pre-authorization required.
Radiotherapy and chemotherapy	Covered, as medically necessary, as part of the hospital admission copayment.
Assistant surgeon	Covered, as medically necessary, pre-authorization is required. Less 30% coinsurance.

Transplant or Graft

Bone, skin and cornea transplant or graft services received by the insured person will be covered, pre-authorization required, less $150 hospital copayment.

Home Health Services

This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification. No additional copayment applies. Copayment apply based on the service given.

Nurse Care	Covered, authorized by physician and Humana, under the supervision of a graduate nurse.
Respiratory therapy care	Covered, less $10 copayment.
Collection of Samples	Covered, for laboratory test, less 30% coinsurance.
Care and maintenance of catheters	Covered, authorized by the provider and Humana, under the supervision of graduate nurse.
Administration of intravenous antibiotics	Covered, subject to Humana’s Case Management Program.
Ulcer care	Covered through Humana's Case Management Program.
Physical therapies	Covered, unlimited, less $10 copayment.
Occupational therapy and speech/language	Covered, unlimited, less $15 copayment.
Hyper alimentation	Covered, less 30% coinsurance.

Skilled Nursing Facility

Skilled nursing facility covered up to a maximum of 120 days per insured per policy year at 100%. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization. Pre-authorization required.

Durable Medical Equipment, Supplies, Prosthesis, Orthosis, and Implants	
Durable Medical Equipment	The purchase or rental of medically necessary Durable Medical Equipment, less 30% coinsurance. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured would pay to buy it, Humana will be covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. In accordance to Act No. 177 of August 13, 2016, as amended by Law 19 of January 12, 2020, the plan covers the supply of a glucose monitor every three (3) years with replacement of damaged equipment, the supply of one (1) glucagon injection and replacement of the same in case of its use or for having expired, and one hundred and fifty (150) strips and one hundred and fifty (150) lancets each month for patients diagnosed with type I diabetes mellitus by a specialist in pediatric endocrinology or endocrinology. Insulin pump is also covered. For the diabetic equipment as well as lancets and strips over 150 per month, pre-authorization is required. Less 30% coinsurance applies.
Prosthesis	Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the insured's physician to be necessary because of growth or change. Less 50% coinsurance. Pre-authorization required.
Orthotics	Covered and supplemented, less 50% coinsurance. No cover prefabricated, over-the-counter – OTC, no cover over-the-counter – OTC. Pre-authorization required.
Implants	Covered, Less 50% coinsurance. Pre-authorization required.
Ambulance Services	
Land transportation by an ambulance between facilities	Covered at 100%, when the patient is hospitalized and needs to be transported to another facility.
Other land transportation by ambulance	Covered, unlimited, less $50 copayment per trip. It includes land transportation from the place of emergency or from the insured home to the hospital or institution. From hospital or institution to the insured residence. When is medically necessary.
Maritime and air transportation ambulance	Covered within Puerto Rico, including Vieques and Culebra, less $50 copayment per trip. Pre-authorization required unless it is a life-or-death emergency.
Cancer Services and Treatments	
Chemotherapy	Covered, less 15% coinsurance. Oral chemotherapy is covered through the Pharmacy Coverage, less 15% coinsurance.
Radiotherapy	Covered at 100%.
Pain management injectable	Covered at 100%. Including intrathecal and intravenous.
Stoma care and maintenance	Covered 100% as part of the office visit copayment or admission copayment.
Maternity Services	
All female, including the wife or cohabitant and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage.	

Hospitalization services	Covered as part of the $150 admission copayment: a. Delivery, including Cesarean Section. b. Delivery and recovery rooms. c. Nursery and incubator. d. Neonatal intensive care unit (NICU). e. Fetal monitoring during delivery. f. Postpartum sterilization before discharge.
Ambulatory services	a. Unlimited pre-natal and post-natal care, less $15 copayment per visit. b. RhoGAM Vaccine, less 30% coinsurance. c. Genetic amniocentesis, less 30% coinsurance. d. Ambulatory sterilization. e. Spontaneous abortion. f. Ambulatory fetal monitoring, less 30% coinsurance. g. Biophysical profile covered for high-risk cases.
Pediatric Services	
Pediatrician	Unlimited visits, less $15 office visit copayment.
Well Child Care	Covered, less $15 office visit copayment.
Universal Neonatal Hearing Screening	Covered at 100%.
Annual Exam	Covered, physical and mental evaluation, oral health, hearing, and vision screening at 100%.
Circumcision and Dilatation	Covered, less $15 office visit copayment.
Immunizations	Covered at 100% according to established medical practices and as recommended by the American Academy of Pediatrics.
Ventilators for Children	Coverage for technological equipment including eight (8) hours daily shift of a skilled nurse with knowledge in respiratory therapy or specialist in respiratory therapy.
Care and treatment of congenital defects and anomalies	Covered when diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any copayment or coinsurance, if any.
Synagis Immunization	Covered as per protocol approved by the Puerto Rico Department of Health for the treatment of the respiratory syncytial virus. Pre-authorization required.
Emergency Room Services	
Resulting from illness	Covered, less $50 copayment.
Resulting from accident	Covered at 100%.
Urgent Care	
Resulting from illness	Covered, less $50 copayment.
Resulting from accident	Covered at 100%.
Cardiovascular Procedures	
Diagnostic tests and treatment	Covered, less 30% coinsurance.
Physician Services	Covered, less $15 office visit copayment.

Surgical Procedures	Covered, less $15 office visit copayment. If the service is rendered in ambulatory facility, applies $75 facility copayment. As part of hospitalization, is covered as part of the $150 hospital admission copayment.
Repair or replacement of heart valves, pacemaker and any other applicable device	Covered when medically necessary. Peacemaker and defibrillator, pre-authorization required.
Neurological Procedures	
Diagnostic tests and treatment	Covered, less 30% coinsurance.
Neurological tests	Covered, less 30% coinsurance.
Physician Services	Covered, less $15 office visit copayment.
Surgical Procedures	Covered including neuroendovascular, less $75 ambulatory facility copayment. As part of hospitalization, is covered as part of the $150 hospital admission copayment.
Repair or replacement of valves, and any other medically necessary device	Covered when neurologically necessary.
Mental Health Services	
Professional visits	Visits to professionals, psychiatrist, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, for adults, children, and teens. Less $15 office visit copayment.
Hospital services	Covered. Two (2) days of partial hospitalization equals one day of regular hospitalization. Less $150 hospital admission copayment.
Psychiatric Emergency Transportation	Covered, less $50 copayment per trip.
Group Therapies	Covered, less $15 office visit copayment.
Alcoholism & Substance Abuse Services	
Professional Visits	Visits to professionals, psychiatrist, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse for adult, children and teens, less $15 copayment.
Ambulatory services	Therapies, treatment, and follow-up in one or more levels of Service, which may combine multiple types of therapies, unlimited. Less $15 office visit copayment.
Residential treatment	Covered, including detox, unlimited. Less $150 hospital admission copayment. Pre-authorization is required.
Hospital services	Covered. Two (2) days of partial hospitalization equals one day of regular hospitalization. Less $150 hospital admission copayment.
Autism	
Cover diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism. These services are subject to any applicable copayment or coinsurance, if any. Services include but are not limited to physical therapies, occupational therapies, speech therapies, and language, among others.	
Other Benefits	
Ambulatory Services	
SPECT Test	One (1) test per policy year, pre-authorization required. Less 30% coinsurance.

Cardiovascular Rehabilitation Services	Cardiovascular rehabilitation services at a dedicated center. Includes services by licensed physicians and registered nurses. Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. This benefit does not include maintenance exercise programs. Program must not exceed twelve (12) sessions in duration. Pre-authorization required. Less $15 office visit copayment or $75 ambulatory facility copayment.
Orthopedic devices	Covered, casts, splints, braces, and crutches.
Laparoscopy	Covered, less $75 ambulatory facility copayment or $150 hospital copayment.
Adult circumcision	Covered, less $15 office visit or $75 ambulatory facility copayment.
Breast Biopsies	Covered, less $75 facility copayment or $150 hospital copayment.
Allergy Vaccines	Covered, up to a maximum of twenty (20) per member, policy year. Less 30% coinsurance.
Epidural blocks	Epidural blocks for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per insured per policy year. Less $15 office visit copayment.
Maxillofacial Surgery	Diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident. Pre-authorization required. Less $15 office visit copayment, less $75 ambulatory facility copayment or $150 hospital admission copayment.
Reconstructive Surgery	Reconstructive surgery for injuries due to an accident while the insured is covered under the policy and is not covered under any other program (ACAA, FSE, etc.). Less $75 ambulatory facility copayment or $150 hospital admission copayment.
Diagnostic tests and treatment associated with Hepatitis C	Covered, less 30% coinsurance.
Amnio Acid Supplements for Phenylketonuria (PKU)	Covered at 100%.

Employee Assistance Program (EAP)

Counseling, support, guidance, and brief psychological therapy	Covered at 100%. For life situations, including labor problems, emotional problems, relationships, and alcohol or drug abuse. Unlimited.

Hospice

Covered for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and as estimated by a physician, are expected to live less than six (6) months as a result of that illness. All the hospice services are subject to $150 admission copayment. All services must be received within a twelve (12) month period month period. Pre-authorization required.

Emergency Services Outside Puerto Rico

Emergency Services received in the United States	Services received with contracted Humana or ChoiceCare providers: • Covered, less $200 emergency copayment. If the insured is hospitalized as part of the emergency, $600 admission applies. Services received with non-contracted Humana or ChoiceCare providers: • Covered, less $200 emergency copayment. If the insured is hospitalized as part of the emergency, $600 admission applies.
Emergency Services received outside the United States or Puerto Rico	The member will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less $50 applicable copayment.

Services not available in Puerto Rico but available in the United States of America

Covered with Humana providers or ChoiceCare, less copays and/or coinsurance applicable in Puerto Rico. Service required pre-authorization by Humana.

Ambulatory Services for Dependent Studying in College in the United States of America

Covered for dependent studying in college in the United States of America. For medical ambulatory services provided by contracted providers in the United States of America. After submitting evidence in accordance with the requirements in the Certificate of Benefits, it will be covered as follows:

- Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Certificate of Benefits. Any copayment, coinsurance and/or deductibles, established will apply.
- If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will the paid based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances, and deductibles, if any. The insured is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges.

Additional Telemedicine Service

Telemedicine is covered for any provider of the telemedicine certified network, less copayment applicable to the service and/or visit according to the provider. Additional virtual consultations, including video, with a primary care physician, is available through the following website: www.mdlive.com/humanapr, less $20 copayment.

During the COVID-19 emergency period, certification is not required, and $0 copayment applies.

Additional Benefits

Pharmacy Coverage	
Rx3 EHB	**Generic drugs (Tier 1)** - $5 retail copayment / $10 mail order copayment. **Preferred brand drugs (Tier 2)** – 85% retail coinsurance / 85% mail order coinsurance. **Non-preferred brand drugs (Tier 3)** – 85% retail coinsurance / 85% mail order coinsurance. **Specialty Drugs** – 85% retail coinsurance. ** *30-day supply for retail and 90-day supply for mail order. Specialty drugs apply 30-day supply for mail order. **When medically necessary, specialty drugs administered in a professional setting, including office or infusion center, are covered less the 30% coinsurance. These drugs are usually dispensed by a contracted specialty pharmacy to be administered on an outpatient setting. Pre-authorization required. **MAC B** If a member buys a brand-name drug, and there is a generic equivalent available, the member must pay the difference between the brand cost and the generic cost plus any applicable brand copayment. If the doctor writes in the prescription "Dispatch as written in the prescription (Dispense as written)", the medication will be dispensed as such, and the insured will only be responsible for the copayment of the brand-name drugs.
Dental Services	
Dental DP	The following services will be covered at 100% with In-Network providers: • Initial oral examination, one (1) every three (3) years • Periodic examination, one (1) every six (6) months • Specific oral evaluation, one (1) every six (6) months • Complete series of radiographs (FMX), one (1) every three (3) years • Panoramic radiographs, up to one (1) every three (3) years • Periapical radiographs, one (1) and five (5) additional per policy year • Bitewing radiographs, one (1) set every twelve (12) months • Prophylaxis adult and child, one (1) every six (6) months • Application of fluoride to children up to nineteen (19) years, one (1) every six (6) months • Sealants application, limited to children up to fourteen (14) years, one (1) treatment per tooth per lifetime in permanent molars and premolars not previously restored. • Application of fluoride varnish for infants and children up to age 5 years, one (1) every six (6) months. • Space maintainers, to replace deciduous teeth that are lost permanently, one (1) per area per lifetime. • Pulp vitality test, one (1) per visit • Re-cementation of space maintainer

Pediatric Vision Care Services	
The vision care benefits described below are available until the 21st birthday.	
Lenses	One (1) set of lenses per insured, per policy year, with $0 copayment. Service is available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers. Lenses for eyeglasses: the lenses included the following selection: • CR-39 Plastic for single vision lenses, bi-focal lenses, or tri-focal lenses • Polycarbonate for single vision lenses
Frames	The insured can select any frame available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers throughout Puerto Rico with $0 copayment. Coverage includes one (1) frame per policy year.
Contact Lenses	Instead of eyeglass benefit (frame and lenses), the member may choose standard disposable contact lenses. The disposable contact lens benefit consists of two (2) boxes per policy year, with $0 copayment. Services are available in the location of the Humana Insurance of Puerto Rico, Inc. participating providers.
Low vision eyeglasses or magnifiers	One (1) pair of low vision eyeglasses or magnifiers as medically necessary for insured with significant loss of vision (low vision), but not total blindness using an exclusive network of Humana Insurance, less $15 copayment.
[Additional Vision Care Services]	
[Vision 471-Vision 486]	[Vision 471 Within the Eyemed network: ➢ Unlimited covered visit exam, less $10 copayment. ➢ Glasses: - $100 discount on retail prices on all mounts, except when prohibited by the manufacturer; In addition, the insured receives a 20% discount on the balance above $100 - $10 copay for simple, bifocal, trifocal, or lenticular plastic lenses. ➢ Contact lenses (A pair of contact lenses is covered instead of glasses): - $110 discount on retail prices in conventional lenses, plus the insured receives a 15% discount on the balance over $110 - $110 discount on retail prices on disposable lenses. - $110 discount on retail prices on medically necessary glasses. ➢ Treatments for lenses available with co-payment from $15 to $65] [Vision 486 Within the Eyemed network: ➢ Glasses: - $75 discount on retail prices on all mounts, except when prohibited by the manufacturer; In addition, the insured receives a 20% discount on the balance exceeding $75 - $15 copay for simple, bifocal, trifocal, or lenticular plastic lenses. ➢ Contact lenses (A pair of contact lenses is covered instead of glasses): - $90 discount on retail prices in conventional lenses, in addition the insured receives a 15% discount on the balance over $90 - $90 discount on retail prices on disposable lenses. - $90 discount on retail prices on medically necessary glasses. ➢ Treatments for lenses available with co-payment from $15 to $ 65]

[Additional Dental Coverage]

[DP0-DP1-DP2-DP3]

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Dental Plan	DP0
Restorative	25% coinsurance
Endodontics	25% coinsurance
Periodontics	Not covered
Prosthesis	Not covered
Oral Surgery	25% coinsurance
Orthodontics	Not covered

Dental Plan	DP1
Restorative	25% coinsurance
Endodontics	25% coinsurance
Periodontics	Not covered
Prosthesis	50% coinsurance, Max $800 per policy year
Oral Surgery	25% coinsurance
Orthodontics	Not covered

Dental Plan	DP2
Restorative	25% coinsurance
Endodontics	25% coinsurance
Periodontics	50% coinsurance, Max $800 per policy year
Prosthesis	50% coinsurance, Max $800 per policy year
Oral Surgery	25% coinsurance
Orthodontics	50% coinsurance, Max $1,000 per policy year

Dental Plan	DP3
Restorative	25% coinsurance
Endodontics	25% coinsurance
Periodontics	50% coinsurance, Max $1,000 per policy year
Prosthesis	50% coinsurance, Max $1,000 per policy year
Oral Surgery	25% coinsurance
Orthodontics	50% coinsurance, Max $1,000 per policy year

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