2023 New Jersey Market Playbook

New Jersey Includes the following submarkets:
Northern New Jersey & Southern New Jersey.

Humana®
A more human way to healthcare™

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Local Agent Support

Local Humana MarketPoint Office

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3000 Atrium Way Suite 200
Mt. Laurel, NJ 08054

Local Sales Manager

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mthompson13@humana.com

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Esiegel1@humana.com

Local Sales Manager

Gloria Martin, Sales Manager
Northern New Jersey
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Broker Relationship Team

Silvana Monsalve, BRM
914-327-6345
smonsalve@humana.com

Rick Urquidi, BRE
502-313-7932
rurquidi@humana.com

Area Market Directors

Downstate NY/ Northern NJ
Cara Brown
757-377-7554

Southern NJ/PA
Mike Bully
561-301-7958

It's essential for you to have a deep knowledge of our products and plan information, and access to leadership. On the human side, we have teams of broker relationship, sales support and other corporate partners always ready to help you out.

Important Agent Contact Information

Scope of Appointment

Telephonic IVR 1-800-903-5493

Establish 3-way call with prospect and IVR. Record Confirmation # on application.

Paper (Submit completed form to Humana, who will retain per 10 year requirement)

Fax : 1-877-889-9936

Mail: Humana MarketPoint | PO Box 14637 | Lexington, KY 40512

Humana Customer Care 1-800-457-4708 or 1-800-281-6918

Call for all questions about your Medical plan, Prescription Drug Plan, Vision Plan and Dental Plan.

Please note that some of the benefits listed below are only available on certain plans.

Humana at Home ..... Humana.com/AtHome

Humana Well Dine 1-877-402-1054

Go365® (Rewards Program) Humana.com/go365

SilverSneakers ..... SilverSneakers.com

Philips Lifeline 1-855-569-0605

MotiveCare Transportation 1-866-588-5122

TruHearing 1-844-255-7146

Other important numbers and websites

Medicare National 1-800-MEDICARE (1-800-633-4227)

Social Security National 1-800-772-1213

CenterWell Pharmacy (formerly Humana Pharmacy)

Call CenterWell Pharmacy 1-855-318-3756 (TTY:711)

Create an Account and Order Online Go to: CenterWellStartNew.com

Over the Counter Supplies (OTC) 1-855-211-8370

New Jersey

Plan Benefit Highlights

Additional benefits and services your Humana members want and need to help them live a healthy lifestyle.

COVID-19 Testing and Treatment
$0 copay for testing and treatment services for COVID-19.

Virtual Visits or Telehealth Services
Virtual office visits for PCP, urgent care, and behavioral health are now $0 co-pay

Health Essentials Kit.
Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses. Limit one per year.

Healthy Foods Card*
Monthly allowance to help pay for approved healthy foods at participating retailers.

Humana Well Dine ® Meal Program
Humana's meal program for members following an inpatient stay in the hospital or nursing facility stay, or if your member has been diagnosed with a chronic condition. $0 copayment for Humana Well Dine ® meal program. Receive 2 meals per day for 7 days, up to 14 meals delivered to member's home after an inpatient stay in a hospital or nursing facility. Limited to 4 times per year.

Over-the-Counter (OTC) card*
Select plans include a monthly or quarterly allowance for OTC items such as: Vitamins, Pain Relievers, and Cough and cold medicines

Go365 ® by Humana*
Go365 by Humana is a wellness program that rewards Humana members for completing eligible healthy activities. Most Humana Medicare Advantage plans include Go365.

Travel Coverage*
As a member of a Humana PPO, they will have the benefit to use Humana's network of providers across the U.S. (not available in all counties).

SilverSneakers ® fitness program*
$0 copayment for SilverSneakers®. The fitness program includes access to 16,000+ participating locations and signature group exercise classes led by certified instructors. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.

NOTE:

*Benefit may not be available with all plans.

New Jersey

Northern New Jersey at a Glance

Product

Full PPO and HMO suite of products designed to meet a variety of consumer needs.

5 PPO Options
1 HMO Option
1 MA Only Option
$0 Premium Plan

Service Area

Bergen, Essex, Hudson, Hunterdon, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren

Veterans

- $40 Part B Giveback
- OTC - $60 per quarter
- Transportation – 24 one-way trips (<50 miles per trip)
- Dental, Vision, Hearing and Fitness

Highlights

- Increased Part B premium giveback on select plans.
- Plans include a Debit Card for monthly or quarterly allowance for over-the-counter items such as: Vitamins, Pain Relievers, and Cough and cold medicines.
- Some Humana Plans include Routine non-emergent medical transportation at no additional cost.
- New Part B premium giveback plan(s) available.
- Many Plans include Dental, Vision, Hearing, OTC and SilverSneakers Fitness Benefits.
- Full PPO and HMO suite of products designed to meet a variety of consumer needs.
- MA-Only plan available for customers that get their drug coverage elsewhere, such as Veterans.
- Virtual office visits for PCP, urgent care, and behaviorial health are now $0 co-pay.
- Select plans with lower Rx copays for Tier 1 and Tier2 through the Rx gap coverage.
- Go365® by Humana is a wellness program that rewards your clients for doing healthy activities. Many Humana Medicare Advantage plans include Go365.

New Jersey

Southern New Jersey at a Glance

Product

Full PPO and HMO suite of products designed to meet a variety of consumer needs.

6 PPO Options

1 HMO Option

2 MA Only Options

$0 Premium Plan

Service Area

Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem

Highlights

- Introducing new PPO plans to market.
- New Part B premium giveback plan(s) available.
- Increased Part B premium giveback on select Honor Plans.
- H6622-066-000 has a travel benefit that allows members to see in-network HMO providers while traveling throughout the nation.
- Plans include a Debit Card for monthly or quarterly allowance for over-the-counter items such as: Vitamins, Pain Relievers, and Cough and cold medicines.
- New Flex Card available on H5216-320-000 with an annual allowance of $250 to be used for dental, vision, and hearing needs.
- Expanding HMO Service Area to include Cape May, Mercer, Salem

Veterans

- Highly engaged VSO officers regionally
- $50 & $100 Part B Giveback on Honor Platform
- OTC - $150 per quarter
- Transportation – 24 one-way trips (<50 miles per trip)
- Dental, vision and hearing

New Jersey | Northern New Jersey at a Glance

Network

Humana's provider network includes doctors, hospitals and clinics that contract with Humana to provide services to our members for less than what they typically charge.

- In-network HMO hospitals and provider systems include, but are not limited to, the following: CarePoint (Bayonne Medical Center, Hoboken Medical Center, Christ Hospital), Summit Medical Group, Senior Medical Group, Prime Healthcare Services (St. Clare's, St. Mary's, St. Michaels)
- In-network hospitals and provider systems include, but are not limited to, the following: RWJ Barnabas Health, Atlantic Health System, Princeton Health - Penn Medicine, St. Peter's, St. Luke's Warren Hospital, Valley Hospital, Englewood Hospital, and Vantage Health System.
- Humana PPO Plans have National Network Reciprocity, allowing members to travel with the comfort of knowing they can use any Humana ChoiceCare PPO Network Provider across the country for in-network services.
- HMO plans within the market do not require referrals.
- Heal is an innovative, concierge primary care model that expands your customer's care options by sending Primary Care doctors to their home for the same co-pays or out-of-pocket costs as a traditional PCP.

For a complete list of in-network providers, visit www.Humana.com/PhysicianFinder

New Jersey | Southern New Jersey at a Glance

Network

Humana's provider network includes doctors, hospitals and clinics that contract with Humana to provide services to our members for less than what they typically charge.

- Multiple plans with similar In and Out of network copays.
- Humana PPO Plans have National Network Reciprocity, allowing members to travel with the comfort of knowing they can use any Humana ChoiceCare PPO Network Provider across the country for in-network services.
- In-network hospitals and provider systems include, but are not limited to, the following: Cooper Health, Inspira, Virtua Health, Jefferson Health, Shore Medical, AtlantiCare, Salem Medical, Deborah Heart and Lung, Capital Health as of 10/1, and many more!
- Select HMO Plans have a travel benefit that allows members to see in-network HMO providers while traveling throughout the nation.
- HMO plans within the market do not require referrals.

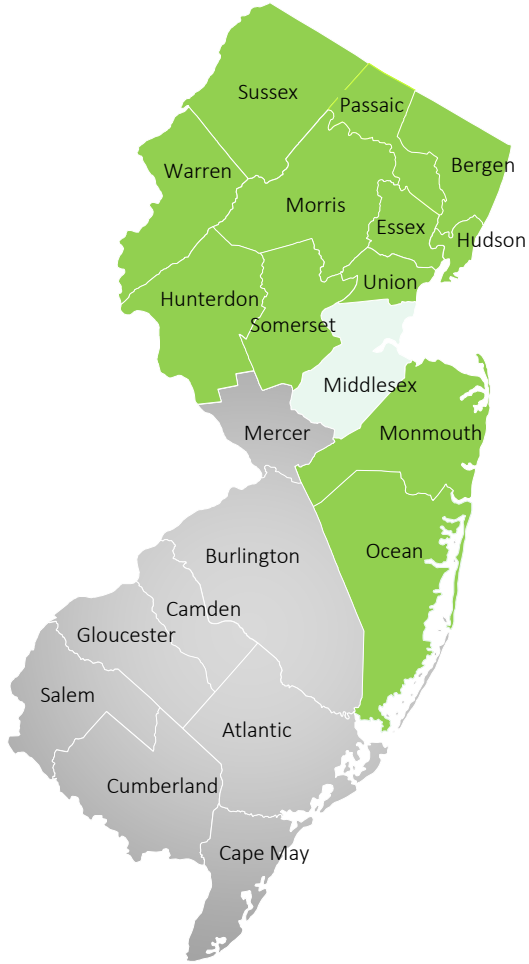
For a complete list of in-network providers, visit www.Humana.com/PhysicianFinder

New Jersey

Northern New Jersey at a Glance

Key:

Current Counties

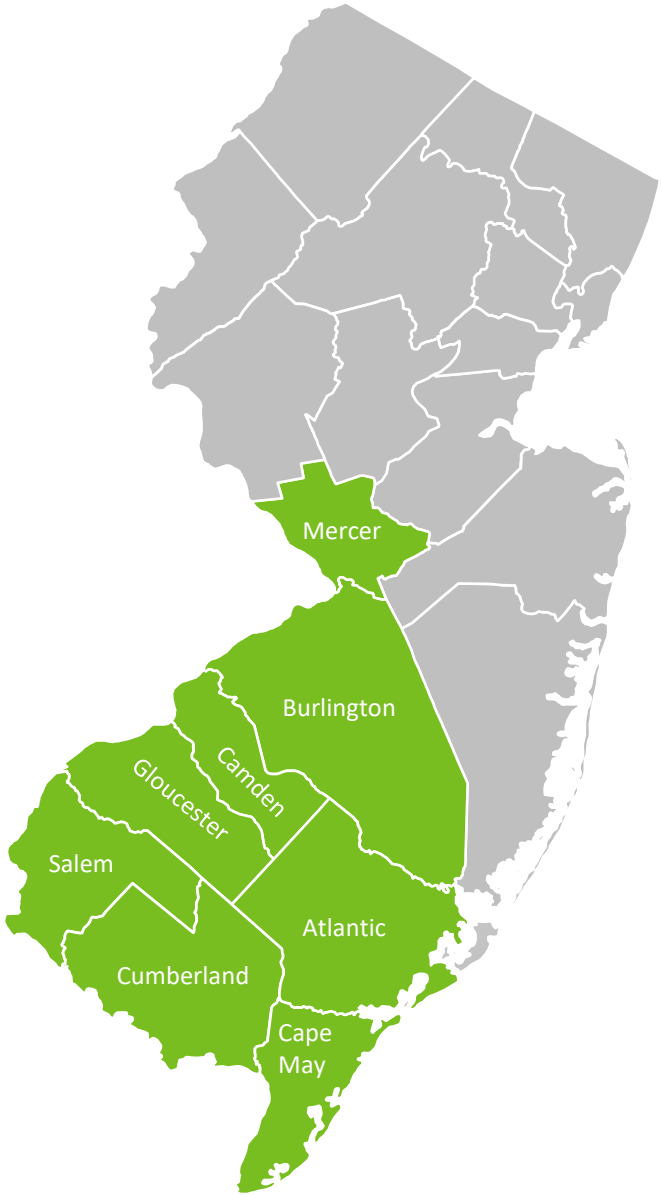


New Jersey

Southern New Jersey at a Glance

Expansion

2023: In All Southern Counties



Northern NJ at a Glance

	HumanaChoice PPO H5216-169	Humana Gold Plus HMO H6622-063	Humana Choice PPO H5216-170	Humana Honor PPO H5216-174
Plan Highlights	$0 Plan Premium LPPO MAPD Plan with passive network.	$0 Plan Premium HMO MAPD Plan with moderate cost shares and additional ancillaries.	Low premium LPPO MAPD Plan. Members who receive Extra Help will pay lower premiums based on their level of LIS.	Honor $0 Premium plan with $40 Part B Giveback LPPO MA Plan with moderate cost shares and additional ancillaries.
Premium / MOOP	$0 / $7,400	$0 / $6,500	$33/ $6,500	$0/ $4500
Giveback	N/A	N/A	N/A	$40 Part B Giveback
PCP / Specialist	$0 copay / $30 copay	$0 copay / $20 copay	$0 copay / $20 copay	$0 Copay / $40 copay
IP Hospital Stay	$320 copay per day 1 - 6 $0 copay per day 7- 90	$320 copay per day 1 - 5 $0 copay per day 6 – 90	$275 copay per day 1-5 $0 copay per day 6-90	$300 copay per day 1-6 $0 copay per day 7-90
RX Preferred Standard	$275 for Tiers 4,5 $0, $5, $47, $100, 28% $10, $20, $47, $100, 28%	$225 deductible Tiers 4, 5 $0, $5, $47, $100, 29% $10, $20, $47, $100, 29%	$250 deductible Tiers 4, 5 $0, $5, $47, $100, 29% $10, $20, $47, $100, 29%	Not Available
OTC	$50 OTC allowance every 3 months**	$100 OTC allowance every 3 months**	$75 OTC allowance every 3 months**	$60 OTC allowance every 3 months*
Insulin Savings Plan	YES	YES	YES	Not Available
Hearing	HER941	HER937	HER944	HER944
Vision	VIS752	VIS735	VIS752	VIS 752
Dental	DEN123	DEN112	DEN978	DEN186
Silver Sneakers	YES	YES	YES	YES
Meals	YES	YES	YES	YES
Transportation	Not Covered	Not Covered	$0 copay 24 one-way trips 25 miles max per trip	$0 copay 24 one-way trips 50 miles max per trip

*Available only through participating retailers and Humana's mail-order pharmacy, CenterWell Pharmacy®.

**Card can be used only at participating retailers

Southern NJ at a Glance

	HumanaChoice PPO H5216-185	Humana Gold Plus HMO H6622-066	HumanaChoice PPO H5216-186	Humana Honor PPO H5216-116 (VA)	Humana Honor PPO H5216-221 (VA)
Plan Highlights	$0 Plan Premium LPPO MAPD Plan with passive network.	$0 Plan Premium HMO MAPD Plan with moderate cost shares and additional ancillaries.	Low premium LPPO MAPD Plan. Members who receive Extra Help will pay lower premiums based on their level of LIS.	Honor $0 Premium plan with $50 Part B Giveback LPPO MA Plan with moderate cost shares and additional ancillaries.	Honor $0 Premium plan with $100 Part B Giveback LPPO MA Plan with moderate cost shares and additional ancillaries.
Premium / MOOP	$0 / $8,300 $10,000 comb OON	$0 / $7,500	$37/ $8,300 $10,000 comb OON	$0 / $3,900 $10,000 comb OON	$0 / $6,700
Giveback	N/A	N/A	N/A	$50 Part B Giveback	$100 Part B Giveback
PCP / Specialist	$0 copay / $35 copay	$0 copay / $35 copay	$0 copay / $30 copay	$0 copay / $25 copay	$10 Copay / $45 copay
IP Hospital Stay	$390 copay per day 1 - 5 $0 copay per day 6 – 90	$335 copay per day 1 - 6 $0 copay per day 7 – 90	$340 copay per day 1-5 $0 copay per day 6-90	$275 copay per day 1-6 $0 copay per day 7-90	$295 copay per day 1-7 $0 copay per day 8-90
RX Preferred Standard	No deductible $0, $0, $47, $100, 33% $10, $20, $47, $100, 33%	No deductible $0, $0, $47, $100, 33% $10, $20, $47, $100, 33%	$505 deductible Tiers 3,4,5 $0, $0, $47, $100, 28% $10, $20, $47, $100, 28%	No deductible Not Available	No deductible Not Available
OTC	$25 Monthly OTC Debit Card	$50 OTC allowance every 3 months*	$75 OTC allowance every 3 months*	$100 OTC allowance every 3 months*	$150 OTC allowance every 3 months*
Insulin Savings Plan	YES	YES	Not Available	Not Available	Not Available
Hearing	HER943	HER939	HER948	HER943	HER943
Vision	VIS751	VIS735	VIS711	VIS752	VIS752
Dental	DEN365 ($1500)	DE325 ($1500)	DEN044 ($2500)	DEN371	DEN044
Silver Sneakers	YES	YES	YES	YES	YES
Meals	YES	YES	YES	YES	YES
Transportation	Not covered	Not covered	$0 copay 12 one-way trips 50 miles max per trip	$0 copay 24 one-way trips 50 miles max per trip	$0 copay 24 one-way trips 50 miles max per trip

*Available only through participating retailers and Humana's mail-order pharmacy, CenterWell Pharmacy®.

**Card can be used only at participating retailers toward the purchase of approved healthy food.

PART B Giveback Plans for Southern and Northern NJ at a Glance

	SNJ- Humana Choice PPO H5216-320	SNJ-Humana Choice PPO H5216-319	NNJ-Humana Choice PPO H5216-342	NNJ-Humana Choice PPO H5216-172
Plan Highlights	$0 Plan Premium LPPO MAPD Plan with moderate cost shares and additional ancillaries.	$0 Plan Premium L PPO MAPD Plan with moderate cost shares and additional ancillaries.	$0 Plan Premium LPPO MAPD Plan with moderate cost shares and additional ancillaries.	$0 Plan Premium LPPO MAPD Plan with moderate cost shares and additional ancillaries.
Premium / MOOP	$0 / $8,300 $10,000 comb OON	$0 / $8,300	$0/ $8,300	$0/$7550
Giveback	$65 Part B Giveback	$102 Part B Giveback	$102 Part B Giveback	$75 Part B Giveback
PCP / Specialist	$0 copay / $45 copay	$0 copay / $50 copay	$0 copay / $50 copay	$0 copay / $50 copay
IP Hospital Stay	$390 copay per day 1 - 5 $0 copay per day 6 – 90	$390 copay per day 1 - 5 $0 copay per day 6 – 90	$390 copay per day 1-5 $0 copay per day 5-90	$550 IN per admission $1000 OON per admission
RX Preferred Standard	$250 deductible for Tiers 4,5 $0, $5, $47, $100, 29% $10, $20, $47, $100, 29%	$505 deductible for Tiers 3,4,5 $0, $5, $47, $100, 25% $10, $20, $47, $100, 25%	$505 deductible Tiers 3, 4, 5 $0, $5, $47, $100, 25% $10, $20, $47, $100, 25%	$295 deductible Tiers 3,4,5 $0, $5, $47, $100, 28% $10/$20/$47/$100/28%
Flex Card	$250	Not Available	Not Available	Not Available
Insulin Savings Plan	YES	YES	YES	Not Available
Hearing	HER941	HER941	HER941	HER941
Vision	VIS751	VIS751	VIS751	VIS752
Dental	DEN355	DEN355	DEN355	DEN123
Silver Sneakers	YES	YES	YES	YES
Meals	YES	YES	YES	YES
Transportation	Not covered	Not covered	Not Covered	Not covered

*Available only through participating retailers and Humana's mail-order pharmacy, CenterWell Pharmacy®.

**Card can be used only at participating retailers toward the purchase of approved healthy food.

Northern NJ Plans Available by County

	PPO					HMO
	H5216-169	H5216-170	H5216-172	H5216-174 (Honor Plan)	H5216-342	H6622-063
Bergen	YES	YES	YES	YES	YES	YES
Essex	YES	YES	YES	YES	YES	YES
Hudson	YES	YES	YES	YES	YES	YES
Hunterdon	YES	YES	YES	YES	YES	YES
Middlesex	N/A	N/A	N/A	N/A	N/A	N/A
Monmouth	YES	YES	YES	YES	YES	YES
Morris	YES	YES	YES	YES	YES	YES
Ocean	YES	YES	YES	YES	YES	YES
Passaic	YES	YES	YES	YES	YES	YES
Somerset	YES	YES	YES	YES	YES	YES
Sussex	YES	YES	YES	YES	YES	YES
Union	YES	YES	YES	YES	YES	YES
Warren	YES	YES	YES	YES	YES	YES

For Agent Use Only

Southern NJ Plans Available by County

	PPO				HMO
	H5216-116 LPPO	H5216-185 LPPO	H5216-186 LPPO	H5216-221 LPPO (VA)	H6622-066 HMO
Atlantic	YES	YES	YES	YES	YES
Burlington	YES	YES	YES	YES	YES
Camden	YES	YES	YES	YES	YES
Cape May	YES	YES	YES	YES	
Cumberland	YES	YES	YES	YES	YES
Gloucester	YES	YES	YES	YES	YES
Mercer	YES	YES	YES	YES	
Salem	YES	YES	YES	YES	

For Agent Use Only

Vision Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
VIS735	$0 copayment for routine exam up to 1 per year. $200 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	
VIS751	$0 copayment for routine exam up to 1 per year. $75 combined maximum benefit coverage amount per year for routine exam. $100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	$0 copayment for routine exam up to 1 per year. $75 combined maximum benefit coverage amount per year for routine exam. $100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VIS752	$0 copayment for routine exam up to 1 per year. $75 combined maximum benefit coverage amount per year for routine exam. $200 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	$0 copayment for routine exam up to 1 per year. $75 combined maximum benefit coverage amount per year for routine exam. $200 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Vision Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
VIS711	$0 copayment for routine exam up to 1 per year. $40 combined maximum benefit coverage amount per year for routine exam. $300 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	$0 copayment for routine exam up to 1 per year. $40 combined maximum benefit coverage amount per year for routine exam. $300 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN123	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for bitewing x-rays up to 1 set(s) per year. 0% coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.	50% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 50% coinsurance for bitewing x-rays up to 1 set(s) per year. 50% coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year. 50% coinsurance for necessary anesthesia with covered service up to unlimited per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DEN112	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. 50% coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year. 70% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. 70% coinsurance for scaling for moderate inflammation up to 1 every 3 years. 70% coinsurance for crown up to 2 per year. 70% coinsurance for periodontal maintenance up to 4 per year. $2000 maximum benefit coverage amount per year for preventive and comprehensive benefits.	

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN978	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. 50% coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year. 70% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. 70% coinsurance for scaling for moderate inflammation up to 1 every 3 years. 70% coinsurance for periodontal maintenance up to 4 per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	50% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 50% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 50% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 50% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 50% coinsurance for necessary anesthesia with covered service up to unlimited per year. 55% coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year. 75% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. 75% coinsurance for scaling for moderate inflammation up to 1 every 3 years. 75% coinsurance for periodontal maintenance up to 4 per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN355	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for emergency diagnostic exam up to 1 per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for periodontal maintenance up to 4 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $25 copayment for scaling for moderate inflammation up to 1 every 3 years. $25 copayment for crown recementation up to 1 every 5 years. $25 copayment for emergency treatment for pain up to 2 per year. $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. 50% coinsurance for occlusal adjustment up to 1 every 3 years. 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years. 50% coinsurance for crown up to 1 per tooth per lifetime. 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year. $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for emergency diagnostic exam up to 1 per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for periodontal maintenance up to 4 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $25 copayment for scaling for moderate inflammation up to 1 every 3 years. $25 copayment for crown recementation up to 1 every 5 years. $25 copayment for emergency treatment for pain up to 2 per year. $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. 50% coinsurance for occlusal adjustment up to 1 every 3 years. 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years. 50% coinsurance for crown up to 1 per tooth per lifetime. 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year. $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN375	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for emergency diagnostic exam up to 1 per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for periodontal maintenance up to 4 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $25 copayment for scaling for moderate inflammation up to 1 every 3 years. $25 copayment for crown recementation up to 1 every 5 years. $25 copayment for emergency treatment for pain up to 2 per year. $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. 50% coinsurance for occlusal adjustment up to 1 every 3 years. 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years. 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year. 50% coinsurance for oral surgery up to 2 per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. 0% coinsurance for emergency diagnostic exam up to 1 per year. 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% coinsurance for periodontal maintenance up to 4 per year. 0% coinsurance for necessary anesthesia with covered service up to unlimited per year. $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $25 copayment for scaling for moderate inflammation up to 1 every 3 years. $25 copayment for crown recementation up to 1 every 5 years. $25 copayment for emergency treatment for pain up to 2 per year. $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. 50% coinsurance for occlusal adjustment up to 1 every 3 years. 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years. 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year. 50% coinsurance for oral surgery up to 2 per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN325	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. $0 copayment for crown up to 1 per tooth per lifetime. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. $0 copayment for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. $1500 maximum benefit coverage amount per year for preventive and comprehensive benefits.	**16A-Preventive Dental** - Dental X-Rays include bitewing x-rays and intraoral x-rays up to 1 set(s) per year, and panoramic film or diagnostic x-rays up to 1 every 5 years. Oral exams include comprehensive oral evaluation or periodontal exam up to 1 every 3 years, emergency diagnostic exam up to 1 per year, and periodic oral exam up to 2 per year. Prophylaxis include periodontal maintenance up to 4 per year, and prophylaxis (cleaning) up to 2 per year. **16B-Comprehensive Dental** - Periodontics include scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years, and scaling for moderate inflammation up to 1 every 3 years. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include partial dentures and complete dentures up to 1 every 5 years, denture adjustment and denture reline and denture repair and denture rebase and tissue conditioning up to 1 per year, occlusal adjustments up to 1 every 3 years. Restorative services include fillings up to unlimited per year, recementation of crown up to 1 every 5 years, crown up to 1 per tooth per lifetime.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN044	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for bridges, complete dentures, crown recementation, denture recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. $0 copayment for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. $0 copayment for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. $2500 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for bridges, complete dentures, crown recementation, denture recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. $0 copayment for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. $0 copayment for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. $2500 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Dental Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
DEN371	$0 copayment for scaling and root planning (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for emergency diagnostic exam up to 1 per year. $0 copayment for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service up to unlimited per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for panoramic film or diagnostic x-rays up to 1 every 5 years. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for emergency diagnostic exam up to 1 per year. $0 copayment for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service up to unlimited per year. $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DEN365	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. $0 copayment for crown up to 1 per tooth per lifetime. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. $0 copayment for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. $1500 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. $0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. $0 copayment for complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. $0 copayment for crown up to 1 per tooth per lifetime. $0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. $0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. $0 copayment for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. $0 copayment for periodontal maintenance up to 4 per year. $0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. $1500 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Hearing Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
HER939	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $499 copayment for each Advanced level hearing aid up to 1 per ear per year. $799 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	
HER941	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $699 copayment for each Advanced level hearing aid up to 1 per ear per year. $999 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $699 copayment for each Advanced level hearing aid up to 1 per ear per year. $999 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. TruHearing provider must be used for in and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
HER937	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $699 copayment for each Advanced level hearing aid up to 1 per ear per year. $999 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	

Hearing Supplemental Benefits

SubPackage Code	Benefit Description - IN	Benefit Description - OON
HER943	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $499 copayment for each Advanced level hearing aid up to 1 per ear per year. $799 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $499 copayment for each Advanced level hearing aid up to 1 per ear per year. $799 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. TruHearing provider must be used for in and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
HER944	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $399 copayment for each Advanced level hearing aid up to 1 per ear per year. $699 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	$0 copayment for routine hearing exams up to 1 per year. $0 copayment for follow-up provider visits up to unlimited per year. $399 copayment for each Advanced level hearing aid up to 1 per ear per year. $699 copayment for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. TruHearing provider must be used for in and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.