



2022 Benefit Grid

Oahu-HI

2022 Individual Medicare Advantage HMO

CHA HMO, Inc.

Humana Gold Plus H0028-048 (HMO)

H0028-048-001

MA-PD

Effective Date - 1/1/2021

Effective Date - 1/1/2022

Deductible AND Maximum Out of Pocket

Plan Information

Maximum Out-of-Pocket
IN

\$5850.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.

\$5850.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.

Premium Information

Plan Information

MA Premium

\$0.00

\$0.00

PD Premium

\$0.00

\$0.00

PD Supplemental Premium

\$0.00

\$0.00

Total Premium

\$0.00

\$0.00

Medical Benefits

Service Place of Treatment

Inpatient Acute Care

IN

Inpatient Hospital

\$350 copay/day Days (1-5)

\$350 copay/day Days (1-5)

Inpatient Hospital

\$0 copay/day Days (6-90)

\$0 copay/day Days (6-90)

Inpatient Mental Health Care

IN

Inpatient Hospital

\$350 copay/day Days (1-5)

\$350 copay/day Days (1-5)

Inpatient Hospital

\$0 copay/day Days (6-90)

\$0 copay/day Days (6-90)

Inpatient Psychiatric Facility

\$350 copay/day Days (1-5):190 day lifetime limit in a psychiatric facility

\$350 copay/day Days (1-5):190 day lifetime limit in a psychiatric facility

Inpatient Psychiatric Facility

\$0 copay/day Days (6-90)

\$0 copay/day Days (6-90)

Skilled Nursing Care

IN

Skilled Nursing Facility

\$0 copay/day Days (1-20)

\$0 copay/day Days (1-20)

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Skilled Nursing Facility	<u>\$178 copay/day Days (21-100)</u>	<u>\$178 copay/day Days (21-100)</u>
Emergency Services		
IN		
Emergency Room-Hospital	<u>\$90 copay waived if admitted within 24 hours</u>	<u>\$90 copay waived if admitted within 24 hours</u>
Worldwide Coverage (MSB)		
OON		
Emergency Room-Hospital	<u>\$90 copay waived if admitted within 24 hours</u>	<u>\$90 copay waived if admitted within 24 hours</u>
Urgently Needed Services		
IN		
Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Specialist's Office	<u>\$40 copay</u>	<u>\$40 copay</u>
Urgent Care Center	<u>\$25 copay</u>	<u>\$25 copay</u>
Home Health Care		
IN		
Member's Home	<u>\$0 copay</u>	<u>\$0 copay</u>
Physician and Professional Services		
IN		
Inpatient Hospital	<u>\$0 copay</u>	<u>\$0 copay</u>
Inpatient Psychiatric Facility	<u>\$0 copay</u>	<u>\$0 copay</u>
Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Dialysis Center	<u>20% coinsurance</u>	<u>20% coinsurance</u>
Specialist's Office	<u>\$40 copay</u>	<u>\$40 copay</u>
Urgent Care Center	<u>\$0 copay</u>	<u>\$0 copay</u>
Freestanding Laboratory	<u>\$0 copay</u>	<u>\$0 copay</u>
Freestanding Radiological Facility	<u>\$0 copay</u>	<u>\$0 copay</u>
Ambulatory Surgical Center	<u>\$0 copay</u>	<u>\$0 copay</u>
Outpatient Hospital	<u>\$0 copay</u>	<u>\$0 copay</u>
Emergency Room-Hospital	<u>\$0 copay</u>	<u>\$0 copay</u>
Skilled Nursing Facility	<u>\$0 copay</u>	<u>\$0 copay</u>
Allergy Shots and Serum		
IN		
Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Specialist's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Acupuncture Services (Medicare Covered)		
IN		
Specialist's Office	<u>\$40 copay</u>	<u>\$40 copay</u>
All Places of Treatment	<u>20 visit(s) per year</u>	<u>20 visit(s) per year</u>
Acupuncture (MSB)		
IN		
Tivity	ACU021: • \$10 copayment for acupuncture visits up to 25 visit(s) per year.	ACU021: • \$10 copayment for acupuncture visits up to 25 visit(s) per year.
Chiropractic Services (Medicare Covered)		
IN		
Specialist's Office	<u>\$20 copay</u>	<u>\$20 copay</u>
Podiatry Services (Medicare Covered)		
IN		
Specialist's Office	<u>\$40 copay</u>	<u>\$40 copay</u>
Podiatry Services (Routine) (MSB)		
IN		
Specialist's Office	<u>\$40 copay</u>	<u>\$40 copay</u>
All Places of Treatment	<u>6 visit(s) per year</u>	<u>6 visit(s) per year</u>

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Mental Health

IN

Specialist's Office	\$35 copay	\$35 copay
Outpatient Hospital	\$35 copay	\$35 copay
Partial Hospitalization	\$35 copay	\$35 copay

Outpatient Substance Abuse Care

IN

Specialist's Office	\$35 copay	\$35 copay
Outpatient Hospital	\$35 copay	\$35 copay
Partial Hospitalization	\$35 copay	\$35 copay

Opioid Treatment Services

IN

Specialist's Office	\$35 copay	\$35 copay
Outpatient Hospital	\$35 copay	\$35 copay
Partial Hospitalization	\$35 copay	\$35 copay

Outpatient Cardiac Therapy

IN

Specialist's Office	\$45 copay	\$45 copay
Outpatient Hospital	\$45 copay	\$45 copay

Outpatient Pulmonary Rehabilitation

IN

Specialist's Office	\$25 copay	\$25 copay
Outpatient Hospital	\$25 copay	\$25 copay

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services

IN

Specialist's Office	\$30 copay	\$30 copay
Outpatient Hospital	\$30 copay	\$30 copay

Outpatient Occupational Therapy

IN

Specialist's Office	\$40 copay	\$40 copay
Comprehensive Outpatient Rehab Facility	\$40 copay	\$40 copay
Outpatient Hospital	\$40 copay	\$40 copay

Outpatient Physical Therapy

IN

Specialist's Office	\$40 copay	\$40 copay
Comprehensive Outpatient Rehab Facility	\$40 copay	\$40 copay
Outpatient Hospital	\$40 copay	\$40 copay

Outpatient Speech Therapy

IN

Specialist's Office	\$40 copay	\$40 copay
Comprehensive Outpatient Rehab Facility	\$40 copay	\$40 copay
Outpatient Hospital	\$40 copay	\$40 copay

Sleep Study (Home Based)

IN

Member's Home	\$0 copay	\$0 copay
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Sleep Study (Facility Based)

IN

Specialist's Office	\$100 copay	\$100 copay
Outpatient Hospital	\$100 copay	\$100 copay

Outpatient Basic Radiological Services

IN

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Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$40 copay	\$40 copay
Urgent Care Center	\$25 copay	\$25 copay
Freestanding Radiological Facility	\$40 copay	\$40 copay
Outpatient Hospital	\$100 copay	\$100 copay
COVID-19 Testing		
IN		
All Places of Treatment	\$0 copay	\$0 copay
COVID-19 Treatment		
IN		
All Places of Treatment	\$0 copay	\$0 copay
Outpatient Diagnostic Procedures and Tests		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$40 copay	\$40 copay
Urgent Care Center	\$25 copay	\$25 copay
Outpatient Hospital	\$170 copay	\$170 copay
Outpatient Lab Services		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Urgent Care Center	\$25 copay	\$0 copay
Freestanding Laboratory	\$20 copay	\$0 copay
Outpatient Hospital	\$25 copay	\$0 copay
Outpatient Advanced Imaging Services (MRI, MRA, PET and CT Scan)		
IN		
Primary Care Physician's Office	\$50 copay	\$50 copay
Specialist's Office	\$150 copay	\$150 copay
Freestanding Radiological Facility	\$180 copay	\$180 copay
Outpatient Hospital	\$250 copay	\$250 copay
Outpatient Nuclear Medicine Services		
IN		
Freestanding Radiological Facility	\$180 copay	\$180 copay
Outpatient Hospital	\$250 copay	\$250 copay
Outpatient Therapeutic Radiology (Radiation Therapy)		
IN		
Specialist's Office	20% coinsurance	20% coinsurance
Freestanding Radiological Facility	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
Diagnostic Mammography		
IN		
Specialist's Office	\$40 copay	\$40 copay
Freestanding Radiological Facility	\$50 copay	\$50 copay
Outpatient Hospital	\$75 copay	\$75 copay
Diagnostic Colonoscopy		
IN		
Ambulatory Surgical Center	\$180 copay	\$180 copay
Outpatient Hospital	\$250 copay	\$250 copay
Surgery Services		
IN		

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Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$40 copay	\$40 copay
Ambulatory Surgical Center	\$180 copay	\$180 copay
Outpatient Hospital	\$250 copay	\$250 copay
Observation Services		
IN		
Outpatient Hospital	\$0 copay	\$0 copay
Wound Care		
IN		
Outpatient Hospital	\$40 copay	\$40 copay
Ambulance Emergency		
IN		
Ground Ambulance	\$250 copay per date of service	\$250 copay per date of service
Air Ambulance	20% coinsurance	20% coinsurance
Ambulance Non-Emergency		
IN		
Ground Ambulance	\$250 copay per date of service	\$250 copay per date of service
Air Ambulance	20% coinsurance	20% coinsurance
Durable Medical Equipment		
IN		
Durable Medical Equipment Provider	20% coinsurance	20% coinsurance
Medical Supplies		
IN		
Medical Supply Provider	20% coinsurance	20% coinsurance
Prosthetics		
IN		
Prosthetics Provider	20% coinsurance	20% coinsurance
Diabetic Shoes and Inserts		
IN		
Prosthetics Provider	\$0 copay	\$0 copay
Durable Medical Equipment Provider	\$0 copay	\$0 copay
Diabetic Monitoring Supplies		
IN		
Preferred Diabetic Supplier	\$0 copay	\$0 copay
Diabetic Supplier	20% coinsurance	20% coinsurance
Network Retail Pharmacy	10% coinsurance	10% coinsurance
Renal Dialysis Services		
IN		
Dialysis Center	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
Kidney Disease Education Services		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Diabetes Self Management Training		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Dental Services (Medicare Covered)		
IN		
Specialist's Office	\$40 copay	\$40 copay

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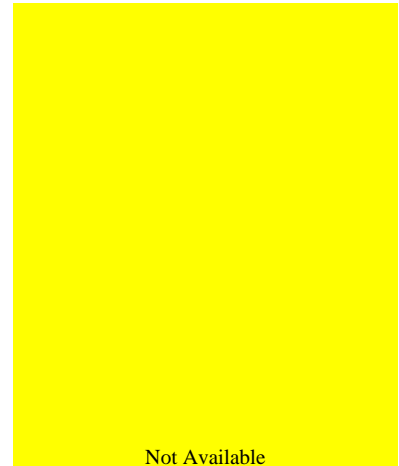
Dental Services (Routine) (MSB)

IN

HumanaDental

DEN110:

- 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 amalgam and/or composite filling up to 2 per year.
- \$1000 maximum benefit coverage amount per year for preventive and comprehensive benefits.



Not Available

HumanaDental

DEN320:

- 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 amalgam and/or composite filling up to 2 per year.
- \$1500 maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

Vision Services (Medicare Covered)

IN

Specialist's Office

\$40 copay

\$40 copay

Diabetic Eye Exam

IN

All Places of Treatment

\$0 copay

\$0 copay

Eyewear (Post Cataract Surgery)

IN

All Places of Treatment

\$0 copay

\$0 copay

Hearing Services (Medicare Covered)

IN

Specialist's Office

\$40 copay

\$40 copay

Hearing Services (Routine) (MSB)

IN

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TruHearing

- HER939:
- \$0 copayment for fitting, routine hearing exams up to 1 per year.
 - \$0 copayment for adjustments up to 2 per year.
 - \$499 copayment for Advanced level hearing aid up to 1 per ear per year.
 - \$799 copayment for Premium level hearing aid up to 1 per ear per year.
 - Note: Includes 48 batteries per aid and 3 year warranty.
 - Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase.

Not Available

TruHearing

Not Available

- HER957:
- \$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 Standard level hearing aid up to 1 per ear 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.

Additional Telehealth Services

IN

Primary Care Physician-Virtual Visit	\$0 copay	\$0 copay
Specialist-Virtual Visit	\$40 copay	\$40 copay
Behavioral Health and Substance Abuse-Virtual Visit	\$0 copay	\$0 copay
Urgent Care-Virtual Visit	\$0 copay	\$0 copay

Preventive Services

Service Place of Treatment

Abdominal Aortic Aneurysm Screening

IN

Specialist's Office	\$0 copay	\$0 copay
Freestanding Radiological Facility	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay

Bone Mass Measurement

IN

Specialist's Office	\$0 copay	\$0 copay
Freestanding Radiological Facility	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay

Cardiovascular Screenings

IN

Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Freestanding Laboratory	\$0 copay	\$0 copay

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Outpatient Hospital	\$0 copay	\$0 copay
Cervical and Vaginal Cancer Screening		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Colorectal Cancer Screening		
IN		
Specialist's Office	\$0 copay	\$0 copay
Ambulatory Surgical Center	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Diabetes Screening		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Freestanding Laboratory	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Immunizations		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
HIV Screening		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Freestanding Laboratory	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Lung Cancer Screening		
IN		
Specialist's Office	\$0 copay	\$0 copay
Freestanding Radiological Facility	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Breast Cancer Screening (Mammogram)		
IN		
Specialist's Office	\$0 copay	\$0 copay
Freestanding Radiological Facility	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Medical Nutrition Therapy		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Specialist's Office	\$0 copay	\$0 copay
Outpatient Hospital	\$0 copay	\$0 copay
Routine Physical Exams		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
All Places of Treatment	1 visit(s) per year	1 visit(s) per year
Welcome to Medicare Visit		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Annual Wellness Visit		
IN		
Primary Care Physician's Office	\$0 copay	\$0 copay
Prostate Cancer Screening Exam		

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IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
	Specialist's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Smoking and Tobacco Cessation Counseling (Medicare covered)			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
	Specialist's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
EKG Screening			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
	Specialist's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
	Outpatient Hospital	<u>\$0 copay</u>	<u>\$0 copay</u>
Glaucoma Screening			
IN	Specialist's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Obesity Screening and Therapy			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Cardiovascular Disease Behavioral Therapy			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
STI Screening and Counseling			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Depression Screening			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Alcohol Misuse Screening and Counseling			
IN	Primary Care Physician's Office	<u>\$0 copay</u>	<u>\$0 copay</u>
Medicare Diabetes Prevention Program (MDPP)			
IN	MDPP Supplier	<u>\$0 copay</u>	<u>\$0 copay</u>

Medicare Part B Drugs

<i>Service</i>	<i>Place of Treatment</i>		
Chemotherapy Drugs and Administration			
IN	Specialist's Office	<u>20% coinsurance</u>	<u>20% coinsurance</u>
	Outpatient Hospital	<u>20% coinsurance</u>	<u>20% coinsurance</u>
Medicare Part B Covered Drugs			
IN	Primary Care Physician's Office	<u>20% coinsurance</u>	<u>20% coinsurance</u>
	Specialist's Office	<u>20% coinsurance</u>	<u>20% coinsurance</u>
	Pharmacy	<u>20% coinsurance</u>	<u>20% coinsurance</u>

Additional Mandatory Supplemental Benefits (MSB)

<i>Service</i>	<i>Place of Treatment</i>		
OTC Drugs and Supplies (MSB)			

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IN
Humana Pharmacy

- OTC190:
- \$30 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.

Not Available

InComm

Not Available

- OTC200:
- \$50 maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers.

Meal Benefit (MSB)

IN
Mom's Meals

- CVD022:
- \$0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis.

- CVD022:
- \$0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis.

Mom's Meals

- WDE001:
- \$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.

- WDE001:
- \$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.

Fitness Program (MSB)

IN
Tivity

- FTP002:
- \$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.
 - Go to SilverSneakers.com to learn more about your benefit.

- FTP002:
- \$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.
 - Go to SilverSneakers.com to learn more about your benefit.

Health Essentials Kit (MSB)

IN
Humana Pharmacy

- CVD019:
- \$0 copayment for Health Essentials Kit from mail order catalog, up to 1 kit per year. Kit includes over-the-counter items useful for the prevention of COVID-19 and other viruses.

Not Available

Incentive Programs

Plan Information

**INC009 Humana Medicare Go365 by Humana
Incentive Program - Incentive Programs**

INC009 - Humana Medicare Go365 by Humana Incentive Program

INC009: Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

INC009: Complete eligible healthy activities, like preventive screenings and exams, and get rewarded.

Value Based Insurance Design (VBID)

Plan Information

VBID Wellness and Health Care Planning - Advance Care Planning

IN

WHP001:

- As a Humana member, you have access to an online advance care planning resource called, MyDirectives® on MyHumana. This resource helps you to create an advance directive where you can combine the elements of a living will, medical power of attorney, do not attempt resuscitation, and an organ donation form.

WHP001:

- As a Humana member, you have access to an online advance care planning resource called, MyDirectives® on MyHumana. This resource helps you to create an advance directive where you can combine the elements of a living will, medical power of attorney, do not attempt resuscitation, and an organ donation form.

Optional Supplemental Benefits

Plan Information

OSB004 MyOption Vision

Premium

\$15.30

\$15.30

Vision Services (Routine)
IN

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 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.

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 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.

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OON

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 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.

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 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.

OSB008 MyOption Enhanced Dental HMO

Premium

\$36.20

Not Available

Dental Services (Routine)
IN

DEN839:

- 0% coinsurance for comprehensive oral evaluation or periodontal exam, panoramic film or diagnostic x-rays up to 1 every 3 years.
- 0% coinsurance for bitewing x-rays up to 1 set(s) per year.
- 0% coinsurance for intraoral x-rays up to 1 per year.
- 0% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic 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.
- 50% coinsurance for recementation up to 1 every 5 years.
- 50% coinsurance for amalgam and/or composite filling, emergency treatment for pain, 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 crown up to 2 per year.
- \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

Humana Gold Plus H0028-048 (HMO)

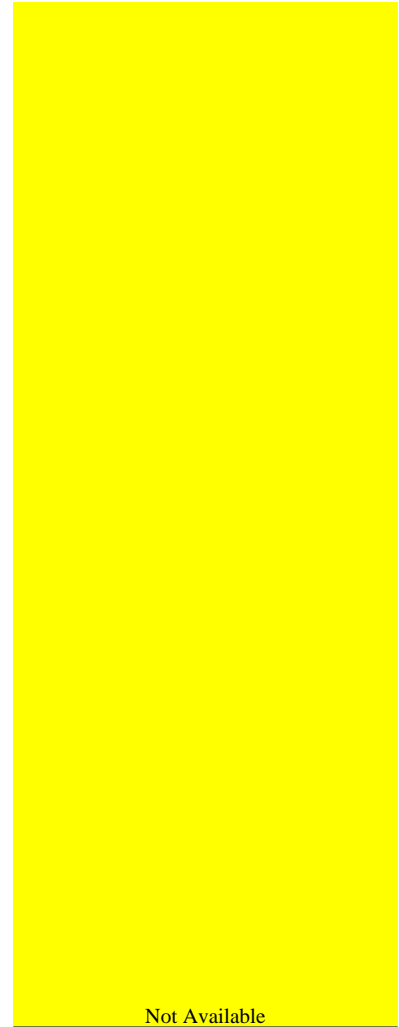
H0028-048-001

Effective Date - 1/1/2021

Effective Date - 1/1/2022

OON

- DEN839:
- 50% coinsurance for comprehensive oral evaluation or periodontal exam, panoramic film or diagnostic x-rays up to 1 every 3 years.
 - 50% coinsurance for bitewing x-rays up to 1 set(s) per year.
 - 50% coinsurance for intraoral x-rays up to 1 per year.
 - 50% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.
 - 50% coinsurance for periodontal maintenance up to 4 per year.
 - 50% coinsurance for necessary anesthesia with covered service up to unlimited per year.
 - 55% coinsurance for recementation up to 1 every 5 years.
 - 55% coinsurance for amalgam and/or composite filling, emergency treatment for pain, 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 crown 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.

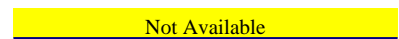


Not Available

OSB034 MyOption Total Dental HMO

Premium
Dental Services (Routine)

\$47.80



Not Available

IN

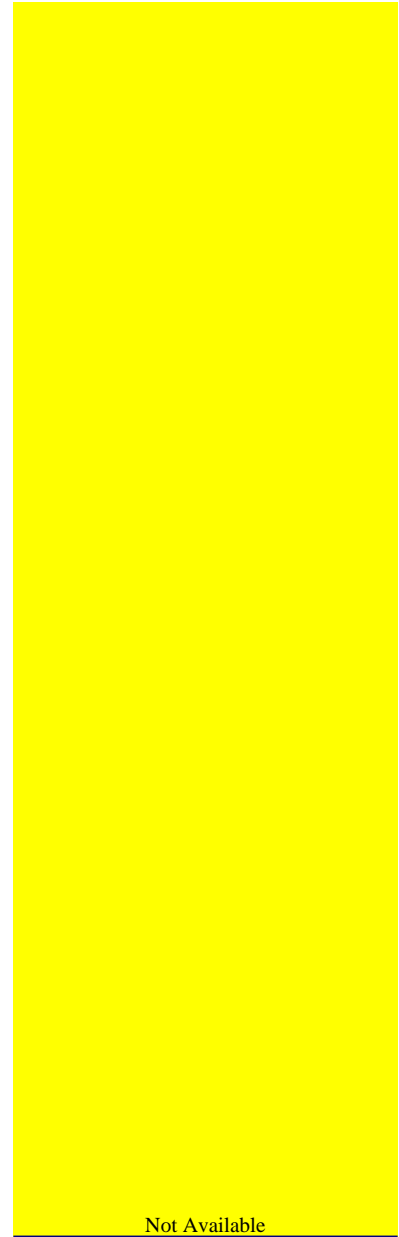
DEN983:

- 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 intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year.
- 0% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic 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.
- 50% coinsurance for recementation up to 1 every 5 years.
- 50% coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year.
- 50% coinsurance for simple or surgical extraction up to unlimited per year.
- 70% coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years.
- 70% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant per year.
- 70% coinsurance for adjustments to dentures, denture relines, root canal up to 1 per year.
- 70% coinsurance for crown, oral surgery up to 2 per year.
- \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

OON

- DEN983:
- 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 intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year.
 - 50% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.
 - 50% coinsurance for periodontal maintenance up to 4 per year.
 - 50% coinsurance for necessary anesthesia with covered service up to unlimited per year.
 - 55% coinsurance for recementation up to 1 every 5 years.
 - 55% coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year.
 - 55% coinsurance for simple or surgical extraction up to unlimited per year.
 - 75% coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years.
 - 75% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant per year.
 - 75% coinsurance for adjustments to dentures, denture reline, root canal up to 1 per year.
 - 75% coinsurance for crown, 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.



Not Available

OSB047 MyOption DEN204

Premium
Dental Services (Routine)

Not Available

\$76.30

IN

DEN204:

- 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 relines, denture repair, tissue conditioning up to 1 per year.
- \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

OON

- DEN204:
- 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 relines, denture repair, tissue conditioning up to 1 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.

Not Available

OSB048 MyOption DEN205

Premium

Not Available

\$105.00

Dental Services (Routine)

IN

DEN205:

- 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years.
- 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- \$25 copayment for crown recementation, denture recementation up to 1 every 5 years.
- \$25 copayment for emergency treatment for pain up to 2 per year.
- 50% coinsurance for occlusal adjustment up to 1 every 3 years.
- 50% coinsurance for bridges, 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 relines, 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.

Not Available

**Humana Gold Plus H0028-048 (HMO)
H0028-048-001**

Effective Date - 1/1/2021

Effective Date - 1/1/2022

OON

<p align="center">DEN205:</p> <ul style="list-style-type: none"> • 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years. • 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • \$25 copayment for crown recementation, denture recementation up to 1 every 5 years. • \$25 copayment for emergency treatment for pain up to 2 per year. • 50% coinsurance for occlusal adjustment up to 1 every 3 years. • 50% coinsurance for bridges, 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.

Not Available

Pharmacy

Plan Information

Important Information

	Enhanced Alternative	Enhanced Alternative
Drug Plan Type	21450-2021 Super National-5 MAPD 1	22520-2022 Super National-5 MAPD 1
Formulary		
Rx Deductible	\$250.00	\$250.00
Deductible Exclusions	Tier 1 & Tier 2 excluded	Tier 1, Tier 2 & Tier 3 excluded
Initial Coverage Limit	\$4130.00	\$4430.00
True Out-of-Pocket	\$6550.00	\$7050.00

Stage 1 Deductible (\$0(Rx Cost) to ded (Rx Cost))

Standard Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	100% coinsurance	\$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance
Standard Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	\$30 copay	\$30 copay

Humana Gold Plus H0028-048 (HMO)
H0028-048-001

	<i>Effective Date - 1/1/2021</i>	<i>Effective Date - 1/1/2022</i>
Tier 2 - All Drugs	\$60 copay	\$60 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	100% coinsurance	\$141 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Preferred Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	\$5 copay	\$3 copay
Tier 2 - All Drugs	\$15 copay	\$12 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	100% coinsurance	\$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance
Preferred Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	\$15 copay	\$9 copay
Tier 2 - All Drugs	\$45 copay	\$36 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	100% coinsurance	\$141 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Standard Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	100% coinsurance	\$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance
Standard Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	\$30 copay	\$30 copay
Tier 2 - All Drugs	\$60 copay	\$60 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	100% coinsurance	\$141 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Preferred Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	\$5 copay	\$3 copay
Tier 2 - All Drugs	\$15 copay	\$12 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	100% coinsurance	\$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance
Preferred Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	\$0 copay	\$0 copay
Tier 2 - All Drugs	\$0 copay	\$0 copay
Tier 3 - Select Insulin Drugs	\$95 copay	\$95 copay
Tier 3 - All Other Drugs	100% coinsurance	\$131 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	100% coinsurance	\$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance
OON Pharmacy - 30 day Supply		

Humana Gold Plus H0028-048 (HMO)
H0028-048-001

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Tier 1 - All Drugs	\$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 2 - All Drugs	\$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - Select Insulin Drugs	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - All Other Drugs		\$47 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
	100% coinsurance	
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance

Stage 2 Initial Coverage (Ded to ICL)

Standard Retail Cost-Sharing - 30 day Supply

Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	\$47 copay	\$47 copay
Tier 4 - All Drugs	\$100 copay	\$100 copay
Tier 5 - All Drugs	28% coinsurance	28% coinsurance

Standard Retail Cost-Sharing - 90 day Supply

Tier 1 - All Drugs	\$30 copay	\$30 copay
Tier 2 - All Drugs	\$60 copay	\$60 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	\$141 copay	\$141 copay
Tier 4 - All Drugs	\$300 copay	\$300 copay

Preferred Retail Cost-Sharing - 30 day Supply

Tier 1 - All Drugs	\$5 copay	\$3 copay
Tier 2 - All Drugs	\$15 copay	\$12 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	\$47 copay	\$47 copay
Tier 4 - All Drugs	\$100 copay	\$100 copay
Tier 5 - All Drugs	28% coinsurance	28% coinsurance

Preferred Retail Cost-Sharing - 90 day Supply

Tier 1 - All Drugs	\$15 copay	\$9 copay
Tier 2 - All Drugs	\$45 copay	\$36 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	\$141 copay	\$141 copay
Tier 4 - All Drugs	\$300 copay	\$300 copay

Standard Mail Order Cost-Sharing - 30 day Supply

Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	\$47 copay	\$47 copay
Tier 4 - All Drugs	\$100 copay	\$100 copay
Tier 5 - All Drugs	28% coinsurance	28% coinsurance

Standard Mail Order Cost-Sharing - 90 day Supply

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	<i>Effective Date - 1/1/2021</i>	<i>Effective Date - 1/1/2022</i>
Tier 1 - All Drugs	\$30 copay	\$30 copay
Tier 2 - All Drugs	\$60 copay	\$60 copay
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	\$141 copay	\$141 copay
Tier 4 - All Drugs	\$300 copay	\$300 copay
Preferred Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	\$5 copay	\$3 copay
Tier 2 - All Drugs	\$15 copay	\$12 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	\$47 copay	\$47 copay
Tier 4 - All Drugs	\$100 copay	\$100 copay
Tier 5 - All Drugs	28% coinsurance	28% coinsurance
Preferred Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	\$0 copay	\$0 copay
Tier 2 - All Drugs	\$0 copay	\$0 copay
Tier 3 - Select Insulin Drugs	\$95 copay	\$95 copay
Tier 3 - All Other Drugs	\$131 copay	\$131 copay
Tier 4 - All Drugs	\$290 copay	\$290 copay
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	\$10 copay	\$10 copay
Tier 2 - All Drugs	\$20 copay	\$20 copay
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	\$47 copay	\$47 copay
Tier 4 - All Drugs	\$100 copay	\$100 copay
Tier 5 - All Drugs	28% coinsurance	28% coinsurance
OON Pharmacy - 30 day Supply		
Tier 1 - All Drugs	\$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 2 - All Drugs	\$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - Select Insulin Drugs	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - All Other Drugs	\$47 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$47 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 4 - All Drugs	\$100 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$100 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 5 - All Drugs	28% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	28% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Stage 3 Coverage Gap (ICL (Rx Cost) to TrOOP)		
Standard Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance

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	<i>Effective Date - 1/1/2021</i>	<i>Effective Date - 1/1/2022</i>
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Tier 5 - All Drugs	25% coinsurance	25% coinsurance
Standard Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Preferred Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Tier 5 - All Drugs	25% coinsurance	25% coinsurance
Preferred Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Standard Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Tier 5 - All Drugs	25% coinsurance	25% coinsurance
Standard Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$105 copay	\$105 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Preferred Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Tier 5 - All Drugs	25% coinsurance	25% coinsurance
Preferred Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$95 copay	\$95 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance

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	<i>Effective Date - 1/1/2021</i>	<i>Effective Date - 1/1/2022</i>
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - Select Insulin Drugs	\$35 copay	\$35 copay
Tier 3 - All Other Drugs	25% coinsurance	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
Tier 5 - All Drugs	25% coinsurance	25% coinsurance
OON Pharmacy - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 2 - All Drugs	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - Select Insulin Drugs	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	\$35 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - All Other Drugs	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 4 - All Drugs	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 5 - All Drugs	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	25% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.

Stage 4 Catastrophic Coverage (after TrOOP)

All Tiers

Member pays the greater of \$3.70 for generic/preferred multi-source drugs/biosimilars and \$9.20 for all other drugs; OR 5% coinsurance.

Member pays the greater of \$3.95 for generic/preferred multi-source drugs/biosimilars and \$9.85 for all other drugs; OR 5% coinsurance.

Additional Information

Specialty drugs (regardless of tier placement) are limited to a one-month supply.

Specialty drugs (regardless of tier placement) are limited to a one-month supply.

VAIS

Plan Information

Complementary Alternative Medicine and Weight Management

CAM004: Discounts on acupuncture, chiropractic, massage, weight management and more. Services must be received from participating Tivity Health's WholeHealth Living providers. To find a participating provider, visit Humana.wholehealthmd.com or call 1(866) 430-8647, (TTY:711). Monday - Friday, 8:30 a.m. to 8 p.m. Eastern time. Not available in Puerto Rico.

CAM004: Discounts on acupuncture, chiropractic, massage, weight management and more. Services must be received from participating Tivity Health's WholeHealth Living providers. To find a participating provider, visit Humana.wholehealthmd.com or call 1(866) 430-8647, (TTY:711). Monday - Friday, 8:30 a.m. to 8 p.m. Eastern time. Not available in Puerto Rico.

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H0028-048-001

Effective Date - 1/1/2021

Effective Date - 1/1/2022

Dental Discount	DND006: Up to 20% OFF exams, cleanings, crowns, specialist care and more from participating HumanaDental providers. To find a participating provider visit Humana.com. To receive the discount show your Humana ID card and your dental discount card. Not available in Puerto Rico or Florida.	DND006: Up to 20% OFF exams, cleanings, crowns, specialist care and more from participating HumanaDental providers. To find a participating HumanaDental provider visit Humana.com or call 1-800-669-6614 (TTY: 711). To receive the discount show your Humana ID card and your dental discount card. Not available in Puerto Rico or Florida.
Hearing Discount	HHE002: Save hundreds of dollars on hearing aid products and services. To find out more about HearUSA, call 1 (844) 340-4615, (TTY:1-888-300-3277), Monday-Friday, 8 a.m. - 8 p.m. Eastern time, to make an appointment with a local provider. Your appointment must be scheduled by HearUSA to make sure you get your discounts. Please have your Humana member ID card when you call. Not available in Florida or Puerto Rico.	HHE002: Save hundreds of dollars on hearing aid products and services. To find out more about HearUSA, call 1 (844) 340-4615, (TTY:1-888-300-3277), Monday-Friday, 8 a.m. - 8 p.m. Eastern time, to make an appointment with a local provider. Your appointment must be scheduled by HearUSA to make sure you get your discounts. Please have your Humana member ID card when you call. Not available in Florida or Puerto Rico.
Hearing Discount	TRU001: Save on hearing aids, plus additional product discounts. Members must schedule an appointment with a TruHearing provider by calling 1-855-299-3591 (TTY: 711) Monday Friday, 7 a.m. 7 p.m. Mountain time. Visit www.truhearing.com to see all TruHearing products. Not available in Florida or Puerto Rico.	TRU001: Save on hearing aids, plus additional product discounts. Members must schedule an appointment with a TruHearing provider by calling 1-855-299-3591 (TTY: 711) Monday Friday, 7 a.m. 7 p.m. Mountain time. Visit www.truhearing.com to get more information. Not available in Florida or Puerto Rico.
Jenny Craig	JCP001: Join for free plus \$200 in food savings plus free coaching (with minimum purchase). Save an extra 5% off your full menu purchases. For more information visit JennyCraig.com/HumanaMedicare or call 1 (877) 536-6970, Monday-Friday 5 a.m.-8 p.m., and weekends 6 a.m.-3 p.m. Pacific time to find a location near you.	Not Available
Lifeline Program	LLP002: Discount savings on Philips Lifeline medical alert systems and medication dispensers. Visit www.offer.lifelinesys.com/Humana for more information. To order, call 1(800) 533-8954 EXT. 54076 (TTY: 711) Monday-Friday 8 a.m.- 9 p.m., and Saturday and Sunday 9 a.m. - 6 p.m. Eastern time. Please have your Humana member ID card when you call and mention program code: MA858.	LLP002: Discount savings on Philips Lifeline medical alert systems and medication dispensers. Visit www.offer.lifelinesys.com/Humana for more information. To order, call 1(800) 533-8954 EXT. 54076 (TTY: 711) Monday-Friday 8 a.m.- 8 p.m., and Saturday and Sunday 9 a.m. - 6 p.m. Eastern time. Please have your Humana member ID card when you call and mention program code: MA858.
Meal Delivery Discount	MOM001: Receive FREE SHIPPING with purchase on meal order delivered direct to your home! Choose from over 50 menu options. To order go online at MomsMeals.com/WellDine or Call 1-877-347-3438 (TTY:711) and mention code: Well Dine. Mom's Meals accepts: Debit, Credit (Visa, MasterCard, etc.).	MOM001: Receive FREE SHIPPING with purchase on meal order delivered direct to your home! Choose from over 50 menu options. To order go online at MomsMeals.com/WellDine or Call 1-877-347-3438 (TTY:711) and mention code: Well Dine. Mom's Meals accepts: Debit, Credit (Visa, MasterCard, etc.).
Rock and Roll Marathon Series	RRM001: 10% OFF 5K, 10K, 1/2 marathon and marathon. US based races only. The Las Vegas running series is not a part of this discount. To find out more, go to Go365.com or call the number on the back of your Humana member ID card. Only available to members who have Go365™ by Humana.	RRM001: 10% OFF 5K, 10K, 1/2 marathon and marathon. US based races only. The Las Vegas running series is not a part of this discount. To find out more, go to Go365.com or call the number on the back of your Humana member ID card. Only available to members who have Go365™ by Humana. This discount is only eligible on races with open registration. Race availability subject to change due to COVID-19 restrictions.
Rx Discount	RXD002: Discounts on prescription medications not covered by Medicare. Show your Humana member ID card at participating pharmacies when you buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.	RXD002: Discounts on prescription medications not covered by Medicare. Show your Humana member ID card at participating pharmacies when you buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

Sam's Club

SAM001: With a Sam's Club membership, you get access to excellent fresh food, high-quality Member's Mark products, and lots of unique and hard to find items at incredible values. With this discount as a part of your plan, you will pay \$25 for a basic membership at Sam's Club which is ordinarily priced at \$45. In order to redeem this offer, go in-store to the Sam's Club nearest you and use discount code Humana at the membership desk. For more information on getting your Sam's Club discounted membership card, visit your local Sam's Club. For a list of full terms and conditions of a Sam's Club basic membership, visit SamsClub.com/termsandconditions or call 1-888-746-7726, Monday - Friday, 8 a.m. - 8 p.m. Eastern Time.

Not Available

Vision Discount

VID001: \$5 OFF Eye Exams, 5 - 40% OFF Eye Glasses, Conventional Contact Lenses, and more. Mention the EyeMed Humana Medicare discount plan ID 9243247. For an EyeMed Select provider, go to Humana.com or call EyeMed at 1(866) 392-6056. Monday - Saturday, 7:30 a.m.-11 p.m., and Sunday, 11 a.m.- 8 p.m. Eastern time. For TTY, call 711 and ask that a TTY translator call (TTY:1-844-230-6498) Monday- Friday, 8 a.m.-5 p.m. Eastern Time.

VID001: \$5 OFF Eye Exams, \$5 - 40% OFF Eye Glasses, Conventional Contact Lenses, and more. Mention the EyeMed Humana Medicare discount plan ID 9243247. For an EyeMed Select provider, go to Humana.com or call EyeMed at 1(866) 392-6056. Monday - Friday, 8 a.m.-2:00 a.m., Saturday, 8:00 a.m. - 11:00 p.m., and Sunday, 11 a.m.- 8:00 p.m. Eastern time (April 1st- September 30th). Or Monday thru Sunday 8:00 a.m - 2:00 a.m. (October 1st-March 31st) . For TTY, call 711 and ask that a TTY translator call (TTY:1-844-230-6498) Monday- Friday, 8 a.m.-5 p.m. Eastern Time.

Service Area

Plan Information

Service Area
Plan Geographic Name

HI:Honolulu

Honolulu County

HI:Honolulu

Honolulu County