# 2022 Benefit Grid

**Kauai/Maui-HI**

**2022 Individual Medicare Advantage HMO**

**CHA HMO, Inc.**

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

**H0028-048-002**

**MA-PD**

## Deductible AND Maximum Out of Pocket

| *Plan Information* | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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* | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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* | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|---|
| **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) |

| | Effective Date - 1/1/2021 | Effective Date - 1/1/2022 |
|---|---|---|
| Skilled Nursing Facility | $178 copay/day Days (21-100) | $178 copay/day Days (21-100) |
| **Emergency Services** | | |
| IN | | |
| Emergency Room-Hospital | $90 copay waived if admitted within 24 hours | $90 copay waived if admitted within 24 hours |
| **Worldwide Coverage (MSB)** | | |
| OON | | |
| Emergency Room-Hospital | $90 copay waived if admitted within 24 hours | $90 copay waived if admitted within 24 hours |
| **Urgently Needed Services** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $45 copay | $45 copay |
| Urgent Care Center | $35 copay | $35 copay |
| **Home Health Care** | | |
| IN | | |
| Member's Home | $0 copay | $0 copay |
| **Physician and Professional Services** | | |
| IN | | |
| Inpatient Hospital | $0 copay | $0 copay |
| Inpatient Psychiatric Facility | $0 copay | $0 copay |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Dialysis Center | 20% coinsurance | 20% coinsurance |
| Specialist's Office | $45 copay | $45 copay |
| Urgent Care Center | $0 copay | $0 copay |
| Freestanding Laboratory | $0 copay | $0 copay |
| Freestanding Radiological Facility | $0 copay | $0 copay |
| Ambulatory Surgical Center | $0 copay | $0 copay |
| Outpatient Hospital | $0 copay | $0 copay |
| Emergency Room-Hospital | $0 copay | $0 copay |
| Skilled Nursing Facility | $0 copay | $0 copay |
| **Allergy Shots and Serum** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $0 copay | $0 copay |
| **Acupuncture Services (Medicare Covered)** | | |
| IN | | |
| Specialist's Office | $45 copay | $45 copay |
| All Places of Treatment | 20 visit(s) per year | 20 visit(s) per year |
| **Acupuncture (MSB)** | | |
| IN | | |
| Tivity | ACU021:<br>• $10 copayment for acupuncture visits up to 25 visit(s) per year. | ACU021:<br>• $10 copayment for acupuncture visits up to 25 visit(s) per year. |
| **Chiropractic Services (Medicare Covered)** | | |
| IN | | |
| Specialist's Office | $20 copay | $20 copay |
| **Podiatry Services (Medicare Covered)** | | |
| IN | | |
| Specialist's Office | $45 copay | $45 copay |
| **Podiatry Services (Routine) (MSB)** | | |
| IN | | |
| Specialist's Office | $45 copay | $45 copay |
| All Places of Treatment | 6 visit(s) per year | 6 visit(s) per year |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| **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 |
| **Sleep Study (Facility Based)** | | |
| IN | | |
| Specialist's Office | $100 copay | $100 copay |
| Outpatient Hospital | $100 copay | $100 copay |
| **Outpatient Basic Radiological Services** | | |
| IN | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $45 copay | $45 copay |
| Urgent Care Center | $35 copay | $35 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 | $45 copay | $45 copay |
| Urgent Care Center | $35 copay | $35 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 | $35 copay | $35 copay |
| Freestanding Laboratory | $20 copay | $20 copay |
| Outpatient Hospital | $45 copay | $45 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 | $45 copay | $45 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 | | |

| | | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|---|
| | Primary Care Physician's Office | $0 copay | $0 copay |
| | Specialist's Office | $45 copay | $45 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 | $45 copay | $45 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 | $45 copay | $45 copay |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| **Dental Services (Routine) (MSB)** | | |
| IN | | |
| HumanaDental | DEN110:<br>• 0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• 0% coinsurance for bitewing x-rays up to 1 set(s) per year.<br>• 0% coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• 50% coinsurance for amalgam and/or composite filling up to 2 per year.<br>• $1000 maximum benefit coverage amount per year for preventive and comprehensive benefits. | Not Available |
| HumanaDental | Not Available | DEN311:<br>• 0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• 0% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years.<br>• 0% coinsurance for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.<br>• 0% coinsurance for emergency diagnostic exam up to 1 per year.<br>• 0% coinsurance for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• 0% coinsurance for periodontal maintenance up to 4 per year.<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• $25 copayment for amalgam and/or composite filling up to 2 per year.<br>• $1000 maximum benefit coverage amount per year for preventive and comprehensive benefits. |
| **Vision Services (Medicare Covered)** | | |
| IN | | |
| Specialist's Office | $45 copay | $45 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 | $45 copay | $45 copay |
| **Hearing Services (Routine) (MSB)** | | |
| IN | | |

| | | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|---|
| | TruHearing | HER939:<br>• $0 copayment for fitting, routine hearing exams up to 1 per year.<br>• $0 copayment for adjustments up to 2 per year.<br>• $499 copayment for Advanced level hearing aid up to 1 per ear per year.<br>• $799 copayment for Premium level hearing aid up to 1 per ear per year.<br>• Note: Includes 48 batteries per aid and 3 year warranty.<br>• Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. | Not Available |
| | TruHearing | Not Available | HER957:<br>• $0 copayment for routine hearing exams up to 1 per year.<br>• $0 copayment for follow-up provider visits up to unlimited per year.<br>• $399 copayment for each Standard level hearing aid up to 1 per ear per year.<br>• $699 copayment for each Advanced level hearing aid up to 1 per ear per year.<br>• $999 copayment for each Premium level hearing aid up to 1 per ear per year.<br>• Note: Includes 80 batteries per aid and 3 year warranty.<br>• 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 | $45 copay | $45 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 |

| | Effective Date - 1/1/2021 | Effective Date - 1/1/2022 |
|---|---|---|
| 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** | | |

| | Effective Date - 1/1/2021 | Effective Date - 1/1/2022 |
|---|---|---|
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $0 copay | $0 copay |
| **Smoking and Tobacco Cessation Counseling (Medicare covered)** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $0 copay | $0 copay |
| **EKG Screening** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| Specialist's Office | $0 copay | $0 copay |
| Outpatient Hospital | $0 copay | $0 copay |
| **Glaucoma Screening** | | |
| IN | | |
| Specialist's Office | $0 copay | $0 copay |
| **Obesity Screening and Therapy** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| **Cardiovascular Disease Behavioral Therapy** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| **STI Screening and Counseling** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| **Depression Screening** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| **Alcohol Misuse Screening and Counseling** | | |
| IN | | |
| Primary Care Physician's Office | $0 copay | $0 copay |
| **Medicare Diabetes Prevention Program (MDPP)** | | |
| IN | | |
| MDPP Supplier | $0 copay | $0 copay |

## Medicare Part B Drugs

| *Service* / *Place of Treatment* | | |
|---|---|---|
| **Chemotherapy Drugs and Administration** | | |
| IN | | |
| Specialist's Office | 20% coinsurance | 20% coinsurance |
| Outpatient Hospital | 20% coinsurance | 20% coinsurance |
| **Medicare Part B Covered Drugs** | | |
| IN | | |
| Primary Care Physician's Office | 20% coinsurance | 20% coinsurance |
| Specialist's Office | 20% coinsurance | 20% coinsurance |
| Pharmacy | 20% coinsurance | 20% coinsurance |

## Additional Mandatory Supplemental Benefits (MSB)

| *Service* / *Place of Treatment* |
|---|
| **OTC Drugs and Supplies (MSB)** |

| | | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|---|
| IN | | | |
| | Humana Pharmacy | OTC190:<br>• $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. | OTC190:<br>• $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. |
| **Meal Benefit (MSB)** | | | |
| IN | | | |
| | Mom's Meals | CVD022:<br>• $0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis. | CVD022:<br>• $0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis. |
| | Mom's Meals | WDE001:<br>• $0 copayment for Humana Well Dine ® meal program.<br>• 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.<br>• Limited to 4 times per year. | WDE001:<br>• $0 copayment for Humana Well Dine ® meal program.<br>• 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.<br>• Limited to 4 times per year. |
| **Fitness Program (MSB)** | | | |
| IN | | | |
| | Tivity | FTP002:<br>• $0 copayment for SilverSneakers®.<br>• The fitness program includes access to 16,000+ participating locations and signature group exercise classes led by certified instructors.<br>• 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.<br>• Go to SilverSneakers.com to learn more about your benefit. | FTP002:<br>• $0 copayment for SilverSneakers®.<br>• The fitness program includes access to 16,000+ participating locations and signature group exercise classes led by certified instructors.<br>• 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.<br>• Go to SilverSneakers.com to learn more about your benefit. |
| **Health Essentials Kit (MSB)** | | | |
| IN | | | |
| | Humana Pharmacy | CVD019:<br>• $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)

| | Effective Date - 1/1/2021 | Effective Date - 1/1/2022 |
|---|---|---|
| *Plan Information* | | |
| **VBID Wellness and Health Care Planning - Advance Care Planning** | | |
| IN | WHP001:<br>• 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:<br>• 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

| | Effective Date - 1/1/2021 | Effective Date - 1/1/2022 |
|---|---|---|
| *Plan Information* | | |
| **OSB004 MyOption Vision** | | |
| Premium | $15.30 | $15.30 |
| Vision Services (Routine) | | |
| IN | VIS757:<br>• $0 copayment for routine exam up to 1 per year.<br>• $40 combined maximum benefit coverage amount per year for routine exam.<br>• $375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• 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:<br>• $0 copayment for routine exam up to 1 per year.<br>• $40 combined maximum benefit coverage amount per year for routine exam.<br>• $375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• 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. |
| OON | VIS757:<br>• $0 copayment for routine exam up to 1 per year.<br>• $40 combined maximum benefit coverage amount per year for routine exam.<br>• $375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• 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.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. | VIS757:<br>• $0 copayment for routine exam up to 1 per year.<br>• $40 combined maximum benefit coverage amount per year for routine exam.<br>• $375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• 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.<br>• 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) | | |

| | | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|---|
| | IN | DEN839:<br>• 0% coinsurance for comprehensive oral evaluation or periodontal exam, panoramic film or diagnostic x-rays up to 1 every 3 years.<br>• 0% coinsurance for bitewing x-rays up to 1 set(s) per year.<br>• 0% coinsurance for intraoral x-rays up to 1 per year.<br>• 0% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.<br>• 0% coinsurance for periodontal maintenance up to 4 per year.<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• 50% coinsurance for recementation up to 1 every 5 years.<br>• 50% coinsurance for amalgam and/or composite filling, emergency treatment for pain, simple or surgical extraction up to 2 per year.<br>• 70% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• 70% coinsurance for crown up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. | Not Available |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| OON | DEN839:<br>• 50% coinsurance for comprehensive oral evaluation or periodontal exam, panoramic film or diagnostic x-rays up to 1 every 3 years.<br>• 50% coinsurance for bitewing x-rays up to 1 set(s) per year.<br>• 50% coinsurance for intraoral x-rays up to 1 per year.<br>• 50% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.<br>• 50% coinsurance for periodontal maintenance up to 4 per year.<br>• 50% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• 55% coinsurance for recementation up to 1 every 5 years.<br>• 55% coinsurance for amalgam and/or composite filling, emergency treatment for pain, simple or surgical extraction up to 2 per year.<br>• 75% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• 75% coinsurance for crown up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>• 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 | $47.80 | Not Available |
| Dental Services (Routine) | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| IN | DEN983:<br>• 0% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• 0% coinsurance for bitewing x-rays up to 1 set(s) per year.<br>• 0% coinsurance for intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year.<br>• 0% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.<br>• 0% coinsurance for periodontal maintenance up to 4 per year.<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• 50% coinsurance for recementation up to 1 every 5 years.<br>• 50% coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year.<br>• 50% coinsurance for simple or surgical extraction up to unlimited per year.<br>• 70% coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>• 70% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant per year.<br>• 70% coinsurance for adjustments to dentures, denture reline, root canal up to 1 per year.<br>• 70% coinsurance for crown, oral surgery up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. | Not Available |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| OON | DEN983:<br>• 50% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.<br>• 50% coinsurance for bitewing x-rays up to 1 set(s) per year.<br>• 50% coinsurance for intraoral x-rays, panoramic film or diagnostic x-rays up to 1 per year.<br>• 50% coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic exam, prophylaxis (cleaning) up to 2 per year.<br>• 50% coinsurance for periodontal maintenance up to 4 per year.<br>• 50% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• 55% coinsurance for recementation up to 1 every 5 years.<br>• 55% coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year.<br>• 55% coinsurance for simple or surgical extraction up to unlimited per year.<br>• 75% coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years.<br>• 75% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant per year.<br>• 75% coinsurance for adjustments to dentures, denture reline, root canal up to 1 per year.<br>• 75% coinsurance for crown, oral surgery up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. | Not Available |
| **OSB047 MyOption DEN204** | | |
| Premium | Not Available | $76.30 |
| Dental Services (Routine) | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| IN | Not Available | DEN204:<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• $25 copayment for scaling for moderate inflammation up to 1 every 3 years.<br>• $25 copayment for crown recementation up to 1 every 5 years.<br>• $25 copayment for emergency treatment for pain up to 2 per year.<br>• $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.<br>• 50% coinsurance for occlusal adjustment up to 1 every 3 years.<br>• 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years.<br>• 50% coinsurance for crown up to 1 per tooth per lifetime.<br>• 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| OON | | DEN204:<br>• 0% coinsurance for necessary anesthesia with covered service up to unlimited per year.<br>• $25 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• $25 copayment for scaling for moderate inflammation up to 1 every 3 years.<br>• $25 copayment for crown recementation up to 1 every 5 years.<br>• $25 copayment for emergency treatment for pain up to 2 per year.<br>• $25 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.<br>• 50% coinsurance for occlusal adjustment up to 1 every 3 years.<br>• 50% coinsurance for complete dentures, partial dentures up to 1 every 5 years.<br>• 50% coinsurance for crown up to 1 per tooth per lifetime.<br>• 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>• 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) | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| IN | Not Available | DEN205:<br>• 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years.<br>• 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>• $25 copayment for crown recementation, denture recementation up to 1 every 5 years.<br>• $25 copayment for emergency treatment for pain up to 2 per year.<br>• 50% coinsurance for occlusal adjustment up to 1 every 3 years.<br>• 50% coinsurance for bridges, complete dentures, partial dentures up to 1 every 5 years.<br>• 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.<br>• 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year.<br>• 50% coinsurance for oral surgery up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| OON | Not Available | DEN205:<br>• 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.<br>• 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years.<br>• 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.<br>• $25 copayment for crown recementation, denture recementation up to 1 every 5 years.<br>• $25 copayment for emergency treatment for pain up to 2 per year.<br>• 50% coinsurance for occlusal adjustment up to 1 every 3 years.<br>• 50% coinsurance for bridges, complete dentures, partial dentures up to 1 every 5 years.<br>• 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.<br>• 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year.<br>• 50% coinsurance for oral surgery up to 2 per year.<br>• $2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.<br>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

## Pharmacy

### *Plan Information*

#### Important Information

| | | |
|---|---|---|
| Drug Plan Type | Enhanced Alternative | Enhanced Alternative |
| Formulary | 21450-2021 Super National-5 MAPD 1 | 22520-2022 Super National-5 MAPD 1 |
| 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 |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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 | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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 | 100% coinsurance | $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% 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 | | |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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 |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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 |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
|---|---|---|
| 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* | | |
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| 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. |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
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| 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. |

| | *Effective Date - 1/1/2021* | *Effective Date - 1/1/2022* |
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| 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. |
| Vision Discount | Not Available | 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. |
| | 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. | |

## Service Area

***Plan Information***

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| Service Area | HI:Kauai; Maui | HI:Kauai; Maui |
| Plan Geographic Name | Kauai and Maui counties | Kauai and Maui counties |