2022 Benefit Grid

Oahu-HI

2022 Individual Medicare Advantage LPPO

Humana Insurance Company

HumanaChoice H5216-232 (PPO)

H5216-232-001

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	$5350.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.	$5100.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.
	Combined IN/OON	$10000.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.	$10000.00 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	$19.60	$20.60
PD Premium	$35.40	$35.40
PD Supplemental Premium	$0.00	$0.00
Total Premium	**$55.00**	**$56.00**

Medical Benefits

Service	Place of Treatment	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Inpatient Acute Care			
IN			
	Inpatient Hospital	$300 copay/day Days (1-5)	$300 copay/day Days (1-5)
	Inpatient Hospital	$0 copay/day Days (6-90)	$0 copay/day Days (6-90)
OON			
	Inpatient Hospital	40% coinsurance	40% coinsurance
Inpatient Mental Health Care			
IN			
	Inpatient Hospital	$300 copay/day Days (1-5)	$300 copay/day Days (1-5)
	Inpatient Hospital	$0 copay/day Days (6-90)	$0 copay/day Days (6-90)

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Inpatient Psychiatric Facility	$300 copay/day Days (1-5):190 day lifetime limit in a psychiatric facility	$300 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)
OON		
Inpatient Hospital	40% coinsurance	40% coinsurance
Inpatient Psychiatric Facility	40% coinsurance :190 day lifetime limit in a psychiatric facility	40% coinsurance :190 day lifetime limit in a psychiatric facility
Skilled Nursing Care		
IN		
Skilled Nursing Facility	$0 copay/day Days (1-20)	$0 copay/day Days (1-20)
Skilled Nursing Facility	$178 copay/day Days (21-100)	$178 copay/day Days (21-100)
OON		
Skilled Nursing Facility	40% coinsurance Days (1-100)	40% coinsurance Days (1-100)
Emergency Services		
IN		
Emergency Room-Hospital	$90 copay waived if admitted within 24 hours	$90 copay waived if admitted within 24 hours
OON		
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
US Travel Benefit (MSB)		
IN		
Network Provider	UST001: • Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	UST001: • Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.
Urgently Needed Services		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$35 copay	$35 copay
Urgent Care Center	$25 copay	$25 copay
OON		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$35 copay	$35 copay
Urgent Care Center	$25 copay	$25 copay
Home Health Care		
IN		
Member's Home	$0 copay	$0 copay
OON		
Member's Home	40% coinsurance	40% coinsurance
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	$35 copay	$35 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

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Outpatient Hospital	$0 copay	$0 copay
Emergency Room-Hospital	$0 copay	$0 copay
Skilled Nursing Facility	$0 copay	$0 copay
OON		
Inpatient Hospital	$0 copay	$0 copay
Inpatient Psychiatric Facility	$0 copay	$0 copay
Primary Care Physician's Office	$40 copay	$40 copay
Dialysis Center	20% coinsurance	20% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Urgent Care Center	$0 copay	$0 copay
Freestanding Laboratory	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Ambulatory Surgical Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Emergency Room-Hospital	$0 copay	$0 copay
Skilled Nursing Facility	40% coinsurance	40% coinsurance
Allergy Shots and Serum		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$0 copay	$0 copay
Acupuncture Services (Medicare Covered)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Combined IN/OON		
All Places of Treatment	20 visit(s) per year	20 visit(s) per year
Acupuncture (MSB)		
IN		
Tivity	ACU020: • $0 copayment for acupuncture visits up to 25 visit(s) per year.	ACU020: • $0 copayment for acupuncture visits up to 25 visit(s) per year.
Chiropractic Services (Medicare Covered)		
IN		
Specialist's Office	$20 copay	$20 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Podiatry Services (Medicare Covered)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Podiatry Services (Routine) (MSB)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Combined IN/OON		
All Places of Treatment	6 visit(s) per year	6 visit(s) per year
Mental Health		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
Partial Hospitalization	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Partial Hospitalization	40% coinsurance	40% coinsurance
Outpatient Substance Abuse Care		
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
Partial Hospitalization	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Partial Hospitalization	40% coinsurance	40% coinsurance
Opioid Treatment Services		
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
Partial Hospitalization	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Partial Hospitalization	40% coinsurance	40% coinsurance
Outpatient Cardiac Therapy		
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Pulmonary Rehabilitation		
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services		
IN		
Specialist's Office	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Occupational Therapy		
IN		
Specialist's Office	$25 copay	$25 copay
Comprehensive Outpatient Rehab Facility	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Comprehensive Outpatient Rehab Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Physical Therapy		
IN		
Specialist's Office	$25 copay	$25 copay
Comprehensive Outpatient Rehab Facility	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Comprehensive Outpatient Rehab Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Speech Therapy		
IN		
Specialist's Office	$25 copay	$25 copay
Comprehensive Outpatient Rehab Facility	$25 copay	$25 copay
Outpatient Hospital	$25 copay	$25 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Comprehensive Outpatient Rehab Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Sleep Study (Home Based)		
IN		
Member's Home	$0 copay	$0 copay
OON		
Member's Home	40% coinsurance	40% coinsurance
Sleep Study (Facility Based)		
IN		
Specialist's Office	$100 copay	$100 copay
Outpatient Hospital	$100 copay	$100 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Basic Radiological Services		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$35 copay	$25 copay
Urgent Care Center	$25 copay	$25 copay
Freestanding Radiological Facility	$50 copay	$25 copay
Outpatient Hospital	$100 copay	$25 copay
OON		
Primary Care Physician's Office	$40 copay	$40 copay
Specialist's Office	40% coinsurance	40% coinsurance
Urgent Care Center	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
COVID-19 Testing		
IN		
All Places of Treatment	$0 copay	$0 copay
OON		
All Places of Treatment	$0 copay	$0 copay
COVID-19 Treatment		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
IN		
All Places of Treatment	$0 copay	$0 copay
OON		
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	$35 copay	$35 copay
Urgent Care Center	$25 copay	$25 copay
Outpatient Hospital	$150 copay	$150 copay
OON		
Primary Care Physician's Office	$40 copay	$40 copay
Specialist's Office	40% coinsurance	40% coinsurance
Urgent Care Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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
OON		
Primary Care Physician's Office	$40 copay	$40 copay
Specialist's Office	40% coinsurance	40% coinsurance
Urgent Care Center	40% coinsurance	40% coinsurance
Freestanding Laboratory	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Advanced Imaging Services (MRI, MRA, PET and CT Scan)		
IN		
Primary Care Physician's Office	$125 copay	$125 copay
Specialist's Office	$125 copay	$125 copay
Freestanding Radiological Facility	$150 copay	$150 copay
Outpatient Hospital	$220 copay	$220 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Nuclear Medicine Services		
IN		
Freestanding Radiological Facility	$150 copay	$150 copay
Outpatient Hospital	$220 copay	$220 copay
OON		
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Diagnostic Mammography		
IN		
Specialist's Office	$35 copay	$35 copay
Freestanding Radiological Facility	$50 copay	$50 copay
Outpatient Hospital	$75 copay	$75 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Diagnostic Colonoscopy		
IN		
Ambulatory Surgical Center	$150 copay	$150 copay
Outpatient Hospital	$220 copay	$220 copay
OON		
Ambulatory Surgical Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Surgery Services		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$35 copay	$35 copay
Ambulatory Surgical Center	$150 copay	$150 copay
Outpatient Hospital	$220 copay	$220 copay
OON		
Primary Care Physician's Office	$40 copay	$40 copay
Specialist's Office	40% coinsurance	40% coinsurance
Ambulatory Surgical Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Observation Services		
IN		
Outpatient Hospital	$0 copay	$0 copay
OON		
Outpatient Hospital	$0 copay	$0 copay
Wound Care		
IN		
Outpatient Hospital	$35 copay	$35 copay
OON		
Outpatient Hospital	40% coinsurance	40% coinsurance
Ambulance Emergency		
IN		
Ground Ambulance	$250 copay per date of service	$250 copay per date of service
Air Ambulance	20% coinsurance	20% coinsurance
OON		
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
OON		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Ground Ambulance	$250 copay per date of service	$250 copay per date of service
Air Ambulance	20% coinsurance	20% coinsurance
Transportation (Routine) (MSB)		
IN		
ModivCare	TRN141: • $0 copayment for plan approved location up to 12 one-way trip(s) per year by car, van, wheelchair access vehicle. • This benefit is not to exceed 50 miles per trip.	TRN141: • $0 copayment for plan approved location up to 12 one-way trip(s) per year by car, van, wheelchair access vehicle. • This benefit is not to exceed 50 miles per trip.
Durable Medical Equipment		
IN		
Durable Medical Equipment Provider	20% coinsurance	20% coinsurance
OON		
Durable Medical Equipment Provider	40% coinsurance	40% coinsurance
Medical Supplies		
IN		
Medical Supply Provider	20% coinsurance	20% coinsurance
OON		
Medical Supply Provider	40% coinsurance	40% coinsurance
Prosthetics		
IN		
Prosthetics Provider	20% coinsurance	20% coinsurance
OON		
Prosthetics Provider	40% coinsurance	40% coinsurance
Diabetic Shoes and Inserts		
IN		
Prosthetics Provider	$0 copay	$0 copay
Durable Medical Equipment Provider	$0 copay	$0 copay
OON		
Prosthetics Provider	40% coinsurance	40% coinsurance
Durable Medical Equipment Provider	40% coinsurance	40% coinsurance
Diabetic Monitoring Supplies		
IN		
Preferred Diabetic Supplier	$0 copay	$0 copay
Diabetic Supplier	20% coinsurance	20% coinsurance
Network Retail Pharmacy	10% coinsurance	10% coinsurance
OON		
Diabetic Supplier	40% coinsurance	40% coinsurance
Pharmacy	40% coinsurance	40% coinsurance
Renal Dialysis Services		
IN		
Dialysis Center	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
OON		
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Dental Services (Medicare Covered)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Dental Services (Routine) (MSB)		
IN		
HumanaDental	DEN976: • 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 up to 1 set(s) per year. • 0% coinsurance for intraoral x-rays up to 1 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, simple or surgical extraction up to 2 per year. • $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	Not Available

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
HumanaDental	Not Available	DEN351: • 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. • $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.
OON HumanaDental	DEN976: • 50% coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • 50% coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • 50% coinsurance for bitewing x-rays up to 1 set(s) per year. • 50% coinsurance for intraoral x-rays up to 1 per year. • 50% coinsurance for periodic oral exam, prophylaxis (cleaning) up to 2 per year. • 50% coinsurance for necessary anesthesia with covered service up to unlimited per year. • 55% coinsurance for amalgam and/or composite filling, simple or surgical extraction up to 2 per year. • $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	Not Available

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
HumanaDental	Not Available	DEN351: • 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. • $1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Vision Services (Medicare Covered)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Diabetic Eye Exam		
IN		
All Places of Treatment	$0 copay	$0 copay
OON		
All Places of Treatment	40% coinsurance	40% coinsurance
Vision Services (Routine) (MSB)		
IN		
EyeMed Vision	Not Available	VIS751: • $0 copayment for routine exam up to 1 per year. • $75 combined maximum benefit coverage amount per year for routine exam. • $100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.
OON		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
EyeMed Vision	Not Available	VIS751: • $0 copayment for routine exam up to 1 per year. • $75 combined maximum benefit coverage amount per year for routine exam. • $100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Eyewear (Post Cataract Surgery)		
IN		
All Places of Treatment	$0 copay	$0 copay
OON		
All Places of Treatment	40% coinsurance	40% coinsurance
Hearing Services (Medicare Covered)		
IN		
Specialist's Office	$35 copay	$35 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Hearing Services (Routine) (MSB)		
IN		
TruHearing	HER948: • $0 copayment for fitting, routine hearing exams up to 1 per year. • $0 copayment for adjustments up to 2 per year. • $199 copayment for Advanced level hearing aid up to 1 per ear per year. • $499 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.	HER948: • $0 copayment for routine hearing exams up to 1 per year. • $0 copayment for follow-up provider visits up to unlimited per year. • $199 copayment for each Advanced level hearing aid up to 1 per ear per year. • $499 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.
OON		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
TruHearing	HER948: • $0 copayment for fitting, routine hearing exams up to 1 per year. • $0 copayment for adjustments up to 2 per year. • $199 copayment for Advanced level hearing aid up to 1 per ear per year. • $499 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. • TruHearing provider must be used for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	HER948: • $0 copayment for routine hearing exams up to 1 per year. • $0 copayment for follow-up provider visits up to unlimited per year. • $199 copayment for each Advanced level hearing aid up to 1 per ear per year. • $499 copayment for each Premium level hearing aid up to 1 per ear per year. • Note: Includes 80 batteries per aid and 3 year warranty. • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. • TruHearing provider must be used for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Additional Telehealth Services		
IN		
Primary Care Physician-Virtual Visit	$0 copay	$0 copay
Specialist-Virtual Visit	$35 copay	$35 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*	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Bone Mass Measurement		
IN		
Specialist's Office	$0 copay	$0 copay
Freestanding Radiological Facility	$0 copay	$0 copay
Outpatient Hospital	$0 copay	$0 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Laboratory	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Cervical and Vaginal Cancer Screening		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Colorectal Cancer Screening		
IN		
Specialist's Office	$0 copay	$0 copay
Ambulatory Surgical Center	$0 copay	$0 copay
Outpatient Hospital	$0 copay	$0 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Ambulatory Surgical Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Laboratory	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Immunizations		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$0 copay	$0 copay
OON		
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Laboratory	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Lung Cancer Screening		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
IN		
Specialist's Office	$0 copay	$0 copay
Freestanding Radiological Facility	$0 copay	$0 copay
Outpatient Hospital	$0 copay	$0 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Freestanding Radiological Facility	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Routine Physical Exams		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Combined IN/OON		
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Annual Wellness Visit		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Prostate Cancer Screening Exam		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
Specialist's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Smoking and Tobacco Cessation Counseling (Medicare covered)		
IN		
Primary Care Physician's Office	$0 copay	$0 copay

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Specialist's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Glaucoma Screening		
IN		
Specialist's Office	$0 copay	$0 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Obesity Screening and Therapy		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Cardiovascular Disease Behavioral Therapy		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
STI Screening and Counseling		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Depression Screening		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Alcohol Misuse Screening and Counseling		
IN		
Primary Care Physician's Office	$0 copay	$0 copay
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Medicare Diabetes Prevention Program (MDPP)		
IN		
MDPP Supplier	$0 copay	$0 copay
OON		
MDPP Supplier	$0 copay	$0 copay

Medicare Part B Drugs

Service	*Place of Treatment*
Chemotherapy Drugs and Administration	

Service / Place of Treatment	Effective Date - 1/1/2021	Effective Date - 1/1/2022
IN		
Specialist's Office	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% 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
OON		
Primary Care Physician's Office	40% coinsurance	40% coinsurance
Specialist's Office	40% coinsurance	40% coinsurance
Pharmacy	40% coinsurance	40% coinsurance

Additional Mandatory Supplemental Benefits (MSB)

Service / *Place of Treatment*	Effective Date - 1/1/2021	Effective Date - 1/1/2022
OTC Drugs and Supplies (MSB)		
IN		
Humana Pharmacy	OTC063: • $75 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.	OTC063: • $75 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
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		

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

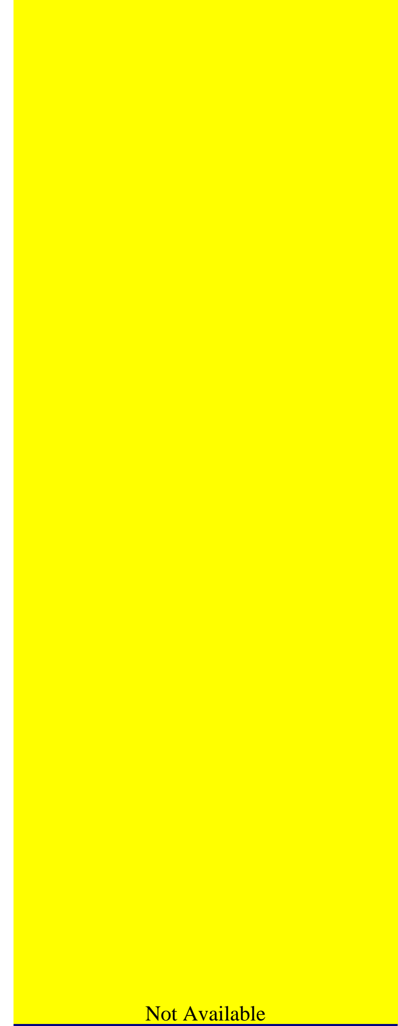
Optional Supplemental Benefits

Plan Information

OSB004 MyOption Vision

Premium	$15.30	Not Available
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.	Not Available

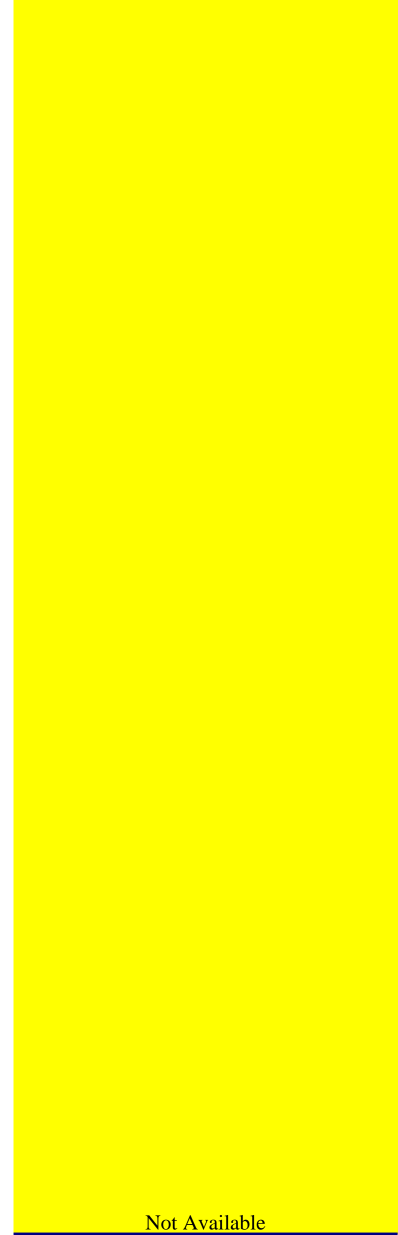
	Effective Date - 1/1/2021	Effective Date - 1/1/2022
OON	VIS757: • $0 copayment for routine exam up to 1 per year. • $40 combined maximum benefit coverage amount per year for routine exam. • $375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting 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.	Not Available
OSB007 MyOption Enhanced Dental PPO		
Premium	$36.20	Not Available
Dental Services (Routine) IN	DEN840: • 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

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
OON	DEN840: • 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

OSB035 MyOption Total Dental PPO

Premium	$47.80	Not Available
Dental Services (Routine)		

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
IN	DEN984: • 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 reline, 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

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
OON	DEN984: • 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	Not Available	$76.30
Dental Services (Routine)		

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
IN	Not Available	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 reline, denture repair, tissue conditioning up to 1 per year. • $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	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 reline, 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.

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: • 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.

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
OON	Not Available	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 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.

Pharmacy

Plan Information

Important Information

Drug Plan Type	Enhanced Alternative	Enhanced Alternative
Formulary	21452-2021 Super National-5 MAPD (AG)	22520-2022 Super National-5 MAPD 1
Rx Deductible	$150.00	$150.00
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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% coinsurance

HumanaChoice H5216-232 (PPO)
H5216-232-001

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$141 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Preferred Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	$3 copay	$3 copay
Tier 2 - All Drugs	$12 copay	$12 copay
Tier 3 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$45 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	$9 copay	$9 copay
Tier 2 - All Drugs	$36 copay	$36 copay
Tier 3 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$135 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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$141 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Preferred Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	$3 copay	$3 copay
Tier 2 - All Drugs	$12 copay	$12 copay
Tier 3 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$45 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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$95 copay
Tier 3 - All Other Drugs	Not Available	$125 copay

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$47 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
Tier 5 - All Drugs	100% coinsurance	100% 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 - All Drugs	100% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$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	Not Available	$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 - All Drugs	$47 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$47 copay
Tier 4 - All Drugs	$100 copay	$100 copay
Tier 5 - All Drugs	30% coinsurance	30% 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 - All Drugs	$141 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$141 copay
Tier 4 - All Drugs	$300 copay	$300 copay
Preferred Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	$3 copay	$3 copay
Tier 2 - All Drugs	$12 copay	$12 copay
Tier 3 - All Drugs	$45 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$45 copay
Tier 4 - All Drugs	$100 copay	$100 copay
Tier 5 - All Drugs	30% coinsurance	30% coinsurance

HumanaChoice H5216-232 (PPO)
H5216-232-001

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Preferred Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	$9 copay	$9 copay
Tier 2 - All Drugs	$36 copay	$36 copay
Tier 3 - All Drugs	$135 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$135 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 - All Drugs	$47 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$47 copay
Tier 4 - All Drugs	$100 copay	$100 copay
Tier 5 - All Drugs	30% coinsurance	30% 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 - All Drugs	$141 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	$141 copay
Tier 4 - All Drugs	$300 copay	$300 copay
Preferred Mail Order Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	$3 copay	$3 copay
Tier 2 - All Drugs	$12 copay	$12 copay
Tier 3 - All Drugs	$45 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$45 copay
Tier 4 - All Drugs	$100 copay	$100 copay
Tier 5 - All Drugs	30% coinsurance	30% 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 - All Drugs	$125 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$95 copay
Tier 3 - All Other Drugs	Not Available	$125 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 - All Drugs	$47 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	$47 copay
Tier 4 - All Drugs	$100 copay	$100 copay
Tier 5 - All Drugs	30% coinsurance	30% 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.

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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 - All 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.	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$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	Not Available	$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	30% 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.	30% 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)

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Standard Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	25% coinsurance

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$105 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	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 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$95 copay
Tier 3 - All Other Drugs	Not Available	25% coinsurance
Tier 4 - All Drugs	25% coinsurance	25% coinsurance
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
Tier 3 - All Drugs	25% coinsurance	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$35 copay
Tier 3 - All Other Drugs	Not Available	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 - 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.	Not Available

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Tier 3 - Select Insulin Drugs	Not Available	$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	Not Available	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

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

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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	Not Available	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.

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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	HI:Honolulu	HI:Honolulu
Plan Geographic Name	Honolulu County	Honolulu County