



2022 Benefit Grid

Kauai/Maui-HI

2022 Individual Medicare Advantage LPPO

Humana Insurance Company

HumanaChoice H5216-232 (PPO)

H5216-232-002

MA-PD

Effective Date - 1/1/2021

Effective Date - 1/1/2022

Deductible AND Maximum Out of Pocket

Plan Information

Maximum Out-of-Pocket
IN

\$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.

\$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.

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

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

Inpatient Acute Care

IN

Inpatient Hospital

\$325 copay/day Days (1-5)

\$325 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

\$325 copay/day Days (1-5)

\$325 copay/day Days (1-5)

Inpatient Hospital

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

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

HumanaChoice H5216-232 (PPO)

H5216-232-002

Effective Date - 1/1/2021

Effective Date - 1/1/2022

	Inpatient Psychiatric Facility	\$325 copay/day Days (1-5):190 day lifetime limit in a psychiatric facility	\$325 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: <ul style="list-style-type: none"> Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area. 	UST001: <ul style="list-style-type: none"> 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

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	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			

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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

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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
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OON	Member's Home	40% coinsurance	40% coinsurance
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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	\$35 copay
	Urgent Care Center	\$25 copay	\$25 copay
	Freestanding Radiological Facility	\$50 copay	\$50 copay
	Outpatient Hospital	\$100 copay	\$100 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
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OON	All Places of Treatment	\$0 copay	\$0 copay
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COVID-19 Treatment

IN	All Places of Treatment	\$0 copay	\$0 copay
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OON	All Places of Treatment	\$0 copay	\$0 copay
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Outpatient Diagnostic Procedures and Tests

IN	Primary Care Physician's Office	\$0 copay	\$0 copay
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	Specialist's Office	\$35 copay	\$35 copay
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	Urgent Care Center	\$25 copay	\$25 copay
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	Outpatient Hospital	\$150 copay	\$150 copay
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OON	Primary Care Physician's Office	\$40 copay	\$40 copay
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	Specialist's Office	40% coinsurance	40% coinsurance
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	Urgent Care Center	40% coinsurance	40% coinsurance
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	Outpatient Hospital	40% coinsurance	40% coinsurance
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Outpatient Lab Services

IN	Primary Care Physician's Office	\$0 copay	\$0 copay
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	Specialist's Office	\$0 copay	\$0 copay
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	Urgent Care Center	\$25 copay	\$25 copay
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	Freestanding Laboratory	\$20 copay	\$20 copay
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	Outpatient Hospital	\$45 copay	\$45 copay
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OON	Primary Care Physician's Office	\$40 copay	\$40 copay
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	Specialist's Office	40% coinsurance	40% coinsurance
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	Urgent Care Center	40% coinsurance	40% coinsurance
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	Freestanding Laboratory	40% coinsurance	40% coinsurance
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	Outpatient Hospital	40% coinsurance	40% coinsurance
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Outpatient Advanced Imaging Services (MRI, MRA, PET and CT Scan)

IN	Primary Care Physician's Office	\$125 copay	\$125 copay
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	Specialist's Office	\$125 copay	\$125 copay
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	Freestanding Radiological Facility	\$150 copay	\$150 copay
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	Outpatient Hospital	\$220 copay	\$220 copay
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OON	Primary Care Physician's Office	40% coinsurance	40% coinsurance
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	Specialist's Office	40% coinsurance	40% coinsurance
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	Freestanding Radiological Facility	40% coinsurance	40% coinsurance
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	Outpatient Hospital	40% coinsurance	40% coinsurance
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Outpatient Nuclear Medicine Services

IN	Freestanding Radiological Facility	\$150 copay	\$150 copay
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	Outpatient Hospital	\$220 copay	\$220 copay
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OON	Freestanding Radiological Facility	40% coinsurance	40% coinsurance
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	Outpatient Hospital	40% coinsurance	40% coinsurance
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Outpatient Therapeutic Radiology (Radiation Therapy)

IN	Specialist's Office	20% coinsurance	20% coinsurance
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	Freestanding Radiological Facility	20% coinsurance	20% coinsurance
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	Outpatient Hospital	20% coinsurance	20% coinsurance
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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			

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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:	TRN141:
	<ul style="list-style-type: none"> \$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. 	<ul style="list-style-type: none"> \$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

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Diabetes Self Management Training

IN

Primary Care Physician's Office
Specialist's Office
Outpatient Hospital

\$0 copay

\$0 copay

\$0 copay

\$0 copay

\$0 copay

\$0 copay

OON

Primary Care Physician's Office
Specialist's Office
Outpatient Hospital

40% coinsurance

40% coinsurance

40% coinsurance

40% coinsurance

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

HumanaDental

- 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.

Not Available

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

HumanaDental

- 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

Not Available

\$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

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

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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

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

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
	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

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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		
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		

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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
	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			

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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

<i>Service</i>	<i>Place of Treatment</i>		
Chemotherapy Drugs and Administration			
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)

<i>Service</i>	<i>Place of Treatment</i>		
OTC Drugs and Supplies (MSB)			
IN	Humana Pharmacy	<ul style="list-style-type: none"> OTC063: \$75 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> CVD022: \$0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis. 	<ul style="list-style-type: none"> CVD022: \$0 copayment for 14 days of meals (28 meals) for members with COVID-19 diagnosis.
	Mom's Meals	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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)			

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IN
Tivity

- FTP002:
- \$0 copayment for SilverSneakers®.
 - The fitness program includes access to 16,000+ participating locations and signature group exercise classes led by certified instructors.
 - At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.
 - Go to SilverSneakers.com to learn more about your benefit.

- FTP002:
- \$0 copayment for SilverSneakers®.
 - The fitness program includes access to 16,000+ participating locations and signature group exercise classes led by certified instructors.
 - At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.
 - Go to SilverSneakers.com to learn more about your benefit.

Health Essentials Kit (MSB)

IN
Humana Pharmacy

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

Not Available

Incentive Programs

Plan Information

INC009 Humana Medicare Go365 by Humana Incentive Program - Incentive Programs

INC009 - Humana Medicare Go365 by Humana Incentive Program

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

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

Value Based Insurance Design (VBID)

Plan Information

VBID Wellness and Health Care Planning - Advance Care Planning

IN

- WHP001:
- As a Humana member, you have access to an online advance care planning resource called, MyDirectives® on MyHumana. This resource helps you to create an advance directive where you can combine the elements of a living will, medical power of attorney, do not attempt resuscitation, and an organ donation form.

- WHP001:
- As a Humana member, you have access to an online advance care planning resource called, MyDirectives® on MyHumana. This resource helps you to create an advance directive where you can combine the elements of a living will, medical power of attorney, do not attempt resuscitation, and an organ donation form.

Optional Supplemental Benefits

Plan Information

OSB004 MyOption Vision

Premium

\$15.30

\$15.30

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Vision Services (Routine)
IN

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.

OON

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

VIS757:

- \$0 copayment for routine exam up to 1 per year.
- \$40 combined maximum benefit coverage amount per year for routine exam.
- \$375 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.
- Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.
- Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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

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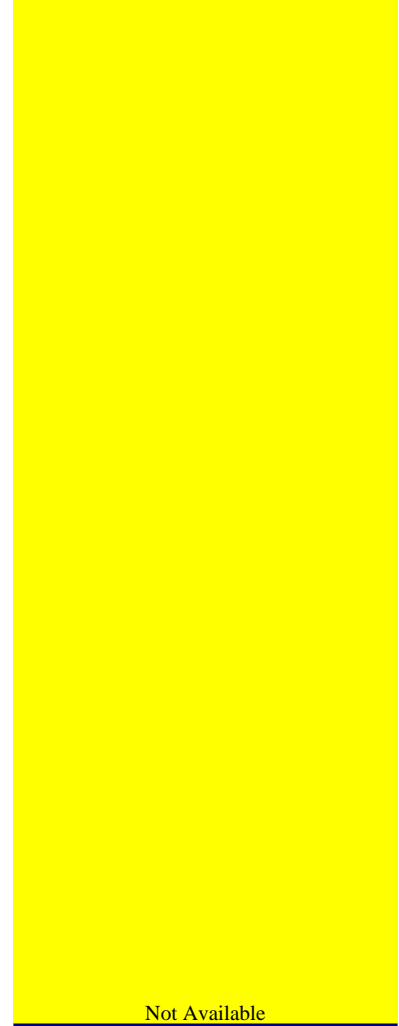
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OON

- 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.



OSB035 MyOption Total Dental PPO

Premium
Dental Services (Routine)

\$47.80



IN

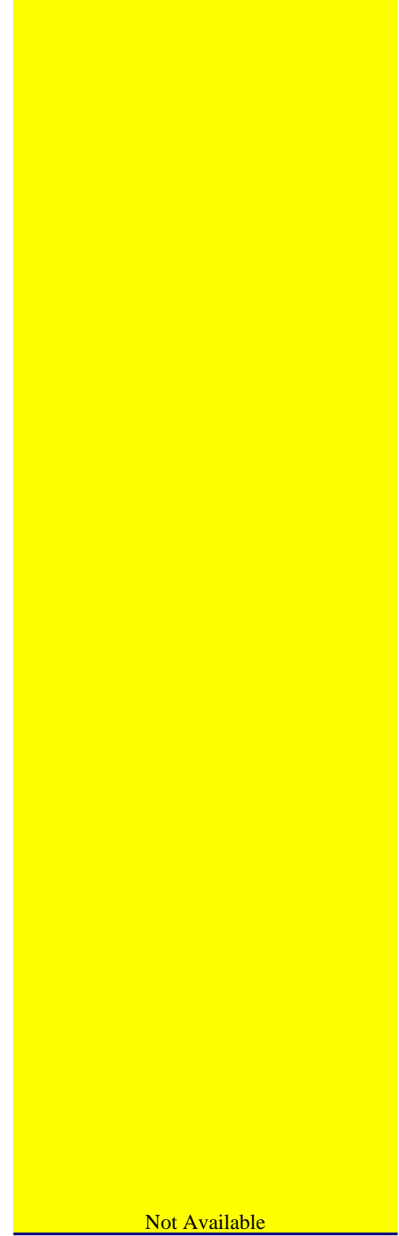
DEN984:

- 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 relines, root canal up to 1 per year.
- 70% coinsurance for crown, oral surgery up to 2 per year.
- \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

OON

- 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
Dental Services (Routine)

Not Available

\$76.30

IN

DEN204:

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

Not Available

OON

<p>DEN204:</p> <ul style="list-style-type: none"> • 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.

Not Available

OSB048 MyOption DEN205

Premium
Dental Services (Routine)

Not Available

\$105.00

IN

DEN205:

- 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years.
- 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years.
- 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- \$25 copayment for crown recementation, denture recementation up to 1 every 5 years.
- \$25 copayment for emergency treatment for pain up to 2 per year.
- 50% coinsurance for occlusal adjustment up to 1 every 3 years.
- 50% coinsurance for bridges, complete dentures, partial dentures up to 1 every 5 years.
- 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.
- 50% coinsurance for adjustments to dentures, denture rebase, denture relines, denture repair, tissue conditioning up to 1 per year.
- 50% coinsurance for oral surgery up to 2 per year.
- \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits.

Not Available

OON

<p>DEN205:</p> <ul style="list-style-type: none"> 0% coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. 0% coinsurance for scaling for moderate inflammation up to 1 every 3 years. 0% coinsurance for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. \$25 copayment for crown recementation, denture recementation up to 1 every 5 years. \$25 copayment for emergency treatment for pain up to 2 per year. 50% coinsurance for occlusal adjustment up to 1 every 3 years. 50% coinsurance for bridges, complete dentures, partial dentures up to 1 every 5 years. 50% coinsurance for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. 50% coinsurance for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year. 50% coinsurance for oral surgery up to 2 per year. \$2000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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Not Available

Pharmacy

Plan Information

Important Information

	Enhanced Alternative	Enhanced Alternative
Drug Plan Type	21452-2021 Super National-5 MAPD (AG)	22520-2022 Super National-5 MAPD 1
Formulary	\$150.00	\$150.00
Rx Deductible	Tier 1 & Tier 2 excluded	Tier 1, Tier 2 & Tier 3 excluded
Deductible Exclusions	\$4130.00	\$4430.00
Initial Coverage Limit	\$6550.00	\$7050.00
True Out-of-Pocket		

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

	Enhanced Alternative	Enhanced Alternative
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

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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

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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

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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.

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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)

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

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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

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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.
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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.
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VAIS

Plan Information

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

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Hearing Discount	<p>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.</p>	<p>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.</p>
Jenny Craig	<p>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.</p>	<p>Not Available</p>
Lifeline Program	<p>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.</p>	<p>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.</p>
Meal Delivery Discount	<p>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.).</p>	<p>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.).</p>
Rock and Roll Marathon Series	<p>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.</p>	<p>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.</p>
Rx Discount	<p>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.</p>	<p>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.</p>
Sam's Club	<p>Not Available</p>	<p>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.</p>

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Vision Discount

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

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

Service Area

Plan Information

Service Area
Plan Geographic Name

HI:Kauai; Maui

Kauai and Maui counties

HI:Kauai; Maui

Kauai and Maui counties