2022 Benefit Grid

Kauai/Maui-HI
2022 Individual Medicare Advantage LPPO
Humana Insurance Company
HumanaChoice H5216-233 (PPO)
H5216-233-002
MA-PD

Deductible AND Maximum Out of Pocket

Plan Information	*Effective Date - 1/1/2021*	*Effective Date - 1/1/2022*
Maximum Out-of-Pocket		
IN	$6700.00 Services not covered by Original Medicare and part D prescription drugs do not apply to the in-network or out-of-network MOOP.	$6700.00 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	$0.00	$0.00
PD Premium	$0.00	$0.00
PD Supplemental Premium	$0.00	$0.00
Total Premium	**$0.00**	**$0.00**

Medical Benefits

Service	*Place of Treatment*	*Effective Date - 1/1/2021*	*Effective Date - 1/1/2022*
Inpatient Acute Care			
	IN		
	Inpatient Hospital	$365 copay/day Days (1-4)	$365 copay/day Days (1-4)
	Inpatient Hospital	$0 copay/day Days (5-90)	$0 copay/day Days (5-90)
	OON		
	Inpatient Hospital	20% coinsurance	20% coinsurance
Inpatient Mental Health Care			
	IN		
	Inpatient Hospital	$365 copay/day Days (1-4)	$365 copay/day Days (1-4)
	Inpatient Hospital	$0 copay/day Days (5-90)	$0 copay/day Days (5-90)

		Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
	Inpatient Psychiatric Facility	$365 copay/day Days (1-3):190 day lifetime limit in a psychiatric facility	$365 copay/day Days (1-3):190 day lifetime limit in a psychiatric facility
	Inpatient Psychiatric Facility	$0 copay/day Days (4-90)	$0 copay/day Days (4-90)
OON			
	Inpatient Hospital	20% coinsurance	20% coinsurance
	Inpatient Psychiatric Facility	20% coinsurance :190 day lifetime limit in a psychiatric facility	20% 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	$10 copay	$5 copay
	Specialist's Office	$50 copay	$50 copay
	Urgent Care Center	$40 copay	$40 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
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	$10 copay	$5 copay
	Dialysis Center	20% coinsurance	20% coinsurance
	Specialist's Office	$50 copay	$50 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	$50 copay	$50 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	ACU021: • $10 copayment for acupuncture visits up to 25 visit(s) per year.	ACU021: • $10 copayment for acupuncture visits up to 25 visit(s) per year.
Chiropractic Services (Medicare Covered)		
IN		
Specialist's Office	$20 copay	$20 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Podiatry Services (Medicare Covered)		
IN		
Specialist's Office	$50 copay	$50 copay
OON		
Specialist's Office	$65 copay	$65 copay
Podiatry Services (Routine) (MSB)		
IN		
Specialist's Office	$50 copay	$50 copay
OON		
Specialist's Office	$65 copay	$65 copay
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	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 copay
Partial Hospitalization	$40 copay	$40 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	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 copay
Partial Hospitalization	$40 copay	$40 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	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 copay
Partial Hospitalization	$40 copay	$40 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	$50 copay	$50 copay
Outpatient Hospital	$50 copay	$50 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Pulmonary Rehabilitation		
IN		
Specialist's Office	$30 copay	$30 copay
Outpatient Hospital	$30 copay	$30 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	$30 copay	$30 copay
Outpatient Hospital	$30 copay	$30 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Occupational Therapy		
IN		
Specialist's Office	$40 copay	$40 copay
Comprehensive Outpatient Rehab Facility	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 copay

	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	$40 copay	$40 copay
Comprehensive Outpatient Rehab Facility	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 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	$40 copay	$40 copay
Comprehensive Outpatient Rehab Facility	$40 copay	$40 copay
Outpatient Hospital	$40 copay	$40 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	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Outpatient Basic Radiological Services		
IN		
Primary Care Physician's Office	$10 copay	$5 copay
Specialist's Office	$50 copay	$50 copay
Urgent Care Center	$40 copay	$40 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
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	$10 copay	$5 copay
Specialist's Office	$50 copay	$50 copay
Urgent Care Center	$40 copay	$40 copay
Outpatient Hospital	$200 copay	$200 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	$40 copay	$40 copay
Freestanding Laboratory	$20 copay	$20 copay
Outpatient Hospital	$50 copay	$50 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	$50 copay	$50 copay
Specialist's Office	$50 copay	$50 copay
Freestanding Radiological Facility	$75 copay	$75 copay
Outpatient Hospital	$110 copay	$110 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	$75 copay	$75 copay
Outpatient Hospital	$110 copay	$110 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	$50 copay	$50 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	$300 copay	$300 copay
Outpatient Hospital	$400 copay	$400 copay
OON		
Ambulatory Surgical Center	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Surgery Services		
IN		
Primary Care Physician's Office	$10 copay	$5 copay
Specialist's Office	$50 copay	$50 copay
Ambulatory Surgical Center	$300 copay	$300 copay
Outpatient Hospital	$400 copay	$400 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	$50 copay	$50 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
Durable Medical Equipment		
IN		
Durable Medical Equipment Provider	20% coinsurance	20% coinsurance
OON		
Durable Medical Equipment Provider	30% coinsurance	30% 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	20% coinsurance	20% coinsurance
Durable Medical Equipment Provider	20% coinsurance	20% coinsurance
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
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

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
Specialist's Office	40% coinsurance	40% coinsurance
Outpatient Hospital	40% coinsurance	40% coinsurance
Dental Services (Medicare Covered)		
IN		
Specialist's Office	$50 copay	$50 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Vision Services (Medicare Covered)		
IN		
Specialist's Office	$50 copay	$50 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	VIS776: • $0 copayment for routine exam up to 1 per year. • $130 combined maximum benefit coverage amount per year for routine exam.	Not Available
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		
EyeMed Vision	VIS776: • $0 copayment for routine exam up to 1 per year. • $130 combined maximum benefit coverage amount per year for routine exam. • 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
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	$50 copay	$50 copay
OON		
Specialist's Office	40% coinsurance	40% coinsurance
Hearing Services (Routine) (MSB)		
IN		
Paid on CAS	Not Available	HER724: • $30 copayment for routine hearing exams up to 1 per year.
TruHearing	HER941: • $0 copayment for fitting, routine hearing exams up to 1 per year. • $0 copayment for adjustments up to 2 per year. • $699 copayment for Advanced level hearing aid up to 1 per ear per year. • $999 copayment for Premium level hearing aid up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase.	Not Available
OON		
Paid on CAS	Not Available	HER724: • $35 copayment for routine hearing exams up to 1 per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

		Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
	TruHearing	HER941: • $0 copayment for fitting, routine hearing exams up to 1 per year. • $0 copayment for adjustments up to 2 per year. • $699 copayment for Advanced level hearing aid up to 1 per ear per year. • $999 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.	Not Available
Additional Telehealth Services			
IN			
	Primary Care Physician-Virtual Visit	$0 copay	$0 copay
	Specialist-Virtual Visit	$50 copay	$50 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			

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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		
IN		
Specialist's Office	$0 copay	$0 copay

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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
Specialist's Office	$0 copay	$0 copay

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
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	
IN	

		Effective Date - 1/1/2021	Effective Date - 1/1/2022
	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*		
OTC Drugs and Supplies (MSB)			
IN			
	Humana Pharmacy	OTC187: • $25 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.	OTC187: • $25 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.
Meal Benefit (MSB)			
IN			
	Mom's Meals	CVD022: • $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.

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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	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
OSB005 MyOption Plus		
Premium	$30.50	Not Available
Dental Services (Routine) IN	DEN843: • 0% coinsurance for bitewing x-rays up to 1 set(s) per year. • 0% coinsurance for fluoride treatment, periodic, comprehensive, periodontal, or emergency diagnostic oral evaluation, 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 per year. • 50% coinsurance for amalgam and/or composite filling, emergency treatment for pain, simple or surgical extraction up to 2 per year. • $50 combined deductible per year for comprehensive benefits. • $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*
OON	DEN843: • 30% coinsurance for bitewing x-rays up to 1 set(s) per year. • 30% coinsurance for fluoride treatment, periodic, comprehensive, periodontal, or emergency diagnostic oral evaluation, prophylaxis (cleaning) up to 2 per year. • 30% coinsurance for periodontal maintenance up to 4 per year. • 30% coinsurance for necessary anesthesia with covered service up to unlimited per year. • 55% coinsurance for recementation up to 1 per year. • 55% coinsurance for amalgam and/or composite filling, emergency treatment for pain, simple or surgical extraction up to 2 per year. • $50 combined deductible per year for comprehensive benefits. • $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
Vision Services (Routine) IN	VIS759: • $0 copayment for routine exam up to 1 per year. • $40 combined maximum benefit coverage amount per year for routine exam. • $290 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
OON	VIS759: • $0 copayment for routine exam up to 1 per year. • $40 combined maximum benefit coverage amount per year for routine exam. • $290 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

OSB016 MyOption Platinum Dental

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
Premium	$38.70	$38.70
Dental Services (Routine) IN	DEN887: • 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.	DEN887: • 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.

	Effective Date - 1/1/2021	Effective Date - 1/1/2022
OON	DEN887: • 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.	DEN887: • 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.

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	$275.00	$275.00
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

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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 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	$5 copay	$5 copay
Tier 2 - All Drugs	$15 copay	$15 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
Preferred Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	$15 copay	$15 copay
Tier 2 - All Drugs	$45 copay	$45 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
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	$5 copay	$5 copay
Tier 2 - All Drugs	$15 copay	$15 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
Preferred Mail Order Cost-Sharing - 90 day Supply		

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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	$131 copay
Tier 4 - All Drugs	100% coinsurance	100% coinsurance
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	$10 copay	$10 copay
Tier 2 - All Drugs	$20 copay	$20 copay
Tier 3 - 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	28% coinsurance	28% coinsurance
Standard Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	$30 copay	$30 copay
Tier 2 - All Drugs	$60 copay	$60 copay
Tier 3 - 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	$5 copay	$5 copay
Tier 2 - All Drugs	$15 copay	$15 copay

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
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	28% coinsurance	28% coinsurance
Preferred Retail Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	$15 copay	$15 copay
Tier 2 - All Drugs	$45 copay	$45 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
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	28% coinsurance	28% 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	$5 copay	$5 copay
Tier 2 - All Drugs	$15 copay	$15 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	28% coinsurance	28% coinsurance
Preferred Mail Order Cost-Sharing - 90 day Supply		
Tier 1 - All Drugs	$0 copay	$0 copay
Tier 2 - All Drugs	$0 copay	$0 copay
Tier 3 - All Drugs	$131 copay	Not Available
Tier 3 - Select Insulin Drugs	Not Available	$95 copay
Tier 3 - All Other Drugs	Not Available	$131 copay
Tier 4 - All Drugs	$290 copay	$290 copay
LTC Pharmacy - 31 day Supply		
Tier 1 - All Drugs	$10 copay	$10 copay
Tier 2 - All Drugs	$20 copay	$20 copay
Tier 3 - 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	28% coinsurance	28% coinsurance
OON Pharmacy - 30 day Supply		

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
Tier 1 - All Drugs	$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	$10 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 2 - All Drugs	$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	$20 copay Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Tier 3 - 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	28% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.	28% coinsurance Member pays the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.
Stage 3 Coverage Gap (ICL (Rx Cost) to TrOOP)		
Standard Retail Cost-Sharing - 30 day Supply		
Tier 1 - All Drugs	25% coinsurance	25% coinsurance
Tier 2 - All Drugs	25% coinsurance	25% coinsurance
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

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

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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
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

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.

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
Hearing Discount	HHE002: Save hundreds of dollars on hearing aid products and services. To find out more about HearUSA, call 1 (844) 340-4615, (TTY:1-888-300-3277), Monday-Friday, 8 a.m. - 8 p.m. Eastern time, to make an appointment with a local provider. Your appointment must be scheduled by HearUSA to make sure you get your discounts. Please have your Humana member ID card when you call. Not available in Florida or Puerto Rico.	HHE002: Save hundreds of dollars on hearing aid products and services. To find out more about HearUSA, call 1 (844) 340-4615, (TTY:1-888-300-3277), Monday-Friday, 8 a.m. - 8 p.m. Eastern time, to make an appointment with a local provider. Your appointment must be scheduled by HearUSA to make sure you get your discounts. Please have your Humana member ID card when you call. Not available in Florida or Puerto Rico.
Hearing Discount	TRU001: Save on hearing aids, plus additional product discounts. Members must schedule an appointment with a TruHearing provider by calling 1-855-299-3591 (TTY: 711) Monday Friday, 7 a.m. 7 p.m. Mountain time. Visit www.truhearing.com to see all TruHearing products. Not available in Florida or Puerto Rico.	TRU001: Save on hearing aids, plus additional product discounts. Members must schedule an appointment with a TruHearing provider by calling 1-855-299-3591 (TTY: 711) Monday Friday, 7 a.m. 7 p.m. Mountain time. Visit www.truhearing.com to get more information. Not available in Florida or Puerto Rico.
Jenny Craig	JCP001: Join for free plus $200 in food savings plus free coaching (with minimum purchase). Save an extra 5% off your full menu purchases. For more information visit JennyCraig.com/HumanaMedicare or call 1 (877) 536-6970, Monday-Friday 5 a.m.-8 p.m., and weekends 6 a.m.-3 p.m. Pacific time to find a location near you.	Not Available
Lifeline Program	LLP002: Discount savings on Philips Lifeline medical alert systems and medication dispensers. Visit www.offer.lifelinesys.com/Humana for more information. To order, call 1(800) 533-8954 EXT. 54076 (TTY: 711) Monday-Friday 8 a.m.- 9 p.m., and Saturday and Sunday 9 a.m. - 6 p.m. Eastern time. Please have your Humana member ID card when you call and mention program code: MA858.	LLP002: Discount savings on Philips Lifeline medical alert systems and medication dispensers. Visit www.offer.lifelinesys.com/Humana for more information. To order, call 1(800) 533-8954 EXT. 54076 (TTY: 711) Monday-Friday 8 a.m.- 8 p.m., and Saturday and Sunday 9 a.m. - 6 p.m. Eastern time. Please have your Humana member ID card when you call and mention program code: MA858.
Meal Delivery Discount	MOM001: Receive FREE SHIPPING with purchase on meal order delivered direct to your home! Choose from over 50 menu options. To order go online at MomsMeals.com/WellDine or Call 1-877-347-3438 (TTY:711) and mention code: Well Dine. Mom's Meals accepts: Debit, Credit (Visa, MasterCard, etc.).	MOM001: Receive FREE SHIPPING with purchase on meal order delivered direct to your home! Choose from over 50 menu options. To order go online at MomsMeals.com/WellDine or Call 1-877-347-3438 (TTY:711) and mention code: Well Dine. Mom's Meals accepts: Debit, Credit (Visa, MasterCard, etc.).
Rock and Roll Marathon Series	RRM001: 10% OFF 5K, 10K, 1/2 marathon and marathon. US based races only. The Las Vegas running series is not a part of this discount. To find out more, go to Go365.com or call the number on the back of your Humana member ID card. Only available to members who have Go365™ by Humana.	RRM001: 10% OFF 5K, 10K, 1/2 marathon and marathon. US based races only. The Las Vegas running series is not a part of this discount. To find out more, go to Go365.com or call the number on the back of your Humana member ID card. Only available to members who have Go365™ by Humana. This discount is only eligible on races with open registration. Race availability subject to change due to COVID-19 restrictions.
Rx Discount	RXD002: Discounts on prescription medications not covered by Medicare. Show your Humana member ID card at participating pharmacies when you buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.	RXD002: Discounts on prescription medications not covered by Medicare. Show your Humana member ID card at participating pharmacies when you buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

	Effective Date - 1/1/2021	*Effective Date - 1/1/2022*
Sam's Club		SAM001: With a Sam's Club membership, you get access to excellent fresh food, high-quality Member's Mark products, and lots of unique and hard to find items at incredible values. With this discount as a part of your plan, you will pay $25 for a basic membership at Sam's Club which is ordinarily priced at $45. In order to redeem this offer, go in-store to the Sam's Club nearest you and use discount code Humana at the membership desk. For more information on getting your Sam's Club discounted membership card, visit your local Sam's Club. For a list of full terms and conditions of a Sam's Club basic membership, visit SamsClub.com/termsandconditions or call 1-888-746-7726, Monday - Friday, 8 a.m. - 8 p.m. Eastern Time.
Vision Discount	Not Available	VID001: $5 OFF Eye Exams, $5 - 40% OFF Eye Glasses, Conventional Contact Lenses, and more. Mention the EyeMed Humana Medicare discount plan ID 9243247. For an EyeMed Select provider, go to Humana.com or call EyeMed at 1(866) 392-6056. Monday - Friday, 8 a.m.-2:00 a.m., Saturday, 8:00 a.m. - 11:00 p.m., and Sunday, 11 a.m.- 8:00 p.m. Eastern time (April 1st- September 30th). Or Monday thru Sunday 8:00 a.m - 2:00 a.m. (October 1st-March 31st) . For TTY, call 711 and ask that a TTY translator call (TTY:1-844-230-6498) Monday- Friday, 8 a.m.-5 p.m. Eastern Time.
	VID001: $5 OFF Eye Exams, 5 - 40% OFF Eye Glasses, Conventional Contact Lenses, and more. Mention the EyeMed Humana Medicare discount plan ID 9243247. For an EyeMed Select provider, go to Humana.com or call EyeMed at 1(866) 392-6056.Monday - Saturday, 7:30 a.m.-11 p.m., and Sunday, 11 a.m.- 8 p.m. Eastern time. For TTY, call 711 and ask that a TTY translator call (TTY:1-844-230-6498) Monday- Friday, 8 a.m.-5 p.m. Eastern Time.	

Service Area

Plan Information

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