

2027 STATE HEALTH PLAN COMPARISON

MEDICARE PRIMARY Non-Active Subscribers (COBRA, Direct Bill and Sponsored Dependents)

	HUMANA MEDICARE ADVANTAGE & HUMANA PRESCRIPTION DRUG		STANDARD PPO Plan*			
	Enhanced Plan	Base Plan	Preferred	Access	Non-Preferred	Out-of-Network
Use of Nework Providers	You can see any provider (in or out-of-network) as long as they accept Medicare assignment and will agree to bill Humana. Your copay or coinsurance will be the same.		You pay less when you use Aetna network providers. Deductible & OOP max cross-accumulates and has combined medical and pharmacy.			
Annual Deductible	\$0		\$1,500 Ind \$4,500 Fam	\$3,000 Ind \$9,000 Fam	\$5,000 Ind \$15,000 Fam	\$15,000 Ind \$45,000 Fam
Out-of-Pocket Maximum	\$3,700 Individual No Family Max	\$4,500 Individual No Family Max	\$4,000 Ind \$12,000 Fam	\$6,500 Ind \$16,300 Fam	\$12,000 Ind ACA LIMIT \$24,000 Fam ACA LIMIT	\$36,000 Ind \$72,000 Fam
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%)		30% after deductible is met			50% after deductible
MEDICAL BENEFITS						
Preventive	\$0 (may be charged a copay if other services are provided and billed during visit)		\$0 Preventive Services			
Primary Care Provider (PCP)	\$10	\$20	\$15 Preferred PCP listed on ID card \$40 other PCP listed on ID card \$50 other PCP			50% after deductible
Walk-In Clinic	This is not separated benefit in the Humana plans.		\$40 other PCP on ID card \$50 other PCP			50% after deductible
Specialist	\$45	\$50	\$40	\$65	30% after deductible	50% after deductible
Chiropractic Visit	\$20	\$15	\$62			50% after deductible
Lab Services	\$10 (\$0 if lab test is performed and processed in doctor’s office)	\$40 (\$0 if lab test is performed and processed in doctor’s office)	30% after deductible			50% after deductible
High-Cost Imaging	\$150	\$175	\$400	30% after deductible	\$1,000, then 30% after ded	50% after deductible
Urgent Care	\$40	\$50	\$100			
Emergency Room	\$65 (copay waived with admission)		\$600, then 30% after deductible (copay waived with admission)			
Inpatient Hospital	Days 1-10: \$150/day Days 11+: \$0	Days 1-10: \$200/day Days 11+: \$0	\$750**	\$600, then 30% after ded	\$1,500, then 30% after ded	50% after deductible

*When enrolled in the Standard Plan, cost-sharing between you and the State Health Plan will vary. Medicare pays first. Then, the Standard Plan may help pay some of the costs that Medicare does not cover.

**Facility copay only. Additional cost-share may apply.

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Enhanced Plan		Base Plan	Preferred	Access	Non-Preferred	Out-of-Network
MEDICAL BENEFITS						
\$250			\$600**	\$350, then 30% after ded	\$1,000, then 30% after ded	50% after deductible
\$250			\$400**	30% after deductible	\$1,000, then 30% after ded	50% after deductible
Days 1-20: \$0 Days 21-100: \$50/day			30% after deductible			
20% coinsurance			30% after deductible			
Included						
PHARMACY BENEFITS						
\$2,400 Individual No Family Max			The 70/30 Plan has combined medical & pharmacy			
Retail Purchase from an In-Network Provider – 30-Day Supply						
\$10	\$15	\$25				
\$40	\$50	\$75				
\$50	\$70	Deductible / Coinsurance				
25% coinsurance up to \$100	25% coinsurance up to \$150	\$200				
N/A		\$600				
N/A		Deductible / Coinsurance				
\$0		\$10				
\$0 for Medicare-covered therapeutic CGMs and supplies		CGMs and supplies are considered a Tier 2 member copay				
Member cost share of the Humana Plan’s covered Part D or Part B insulin products will be no more than \$35 for every one-month supply		\$0				
Maintenance Drugs from an In-Network Provider						
UP TO 100-DAY SUPPLY			UP TO 90-DAY SUPPLY			
\$24	\$36	\$75				
\$80	\$100	\$225				
\$100	\$140	Deductible / Coinsurance				
25% coinsurance up to \$200	25% coinsurance up to \$300	\$600				
N/A		\$1,800				
N/A		Deductible / Coinsurance				

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