

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 Network 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 \$24,000 Fam	\$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 a 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. Pharmacy copays and out-of-pocket costs accumulate to the Access Tier deductible/out-of-pocket maximum.

**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			N/A			
PHARMACY BENEFITS						
\$2,400 Individual No Family Max			The Standard 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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