

# 2027 STATE HEALTH PLAN COMPARISON

## MEDICARE PRIMARY Subscribers

|                             | HUMANA MEDICARE ADVANTAGE & HUMANA PRESCRIPTION DRUG                                                                                                                     |                                                                         | 70/30 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.<br>Your copay or coinsurance will be the same. |                                                                         | You pay less when you use Aetna network providers.<br>Deductible & OOP max cross-accumulates and has combined medical and pharmacy. |                             |                              |                              |
| Annual Deductible           | \$0                                                                                                                                                                      |                                                                         | \$1,500 Ind<br>\$4,500 Fam                                                                                                          | \$3,000 Ind<br>\$9,000 Fam  | \$5,000 Ind<br>\$15,000 Fam  | \$15,000 Ind<br>\$45,000 Fam |
| Out-of-Pocket Maximum       | \$3,700 Individual<br>No Family Max                                                                                                                                      | \$4,500 Individual<br>No Family Max                                     | \$4,000 Ind<br>\$12,000 Fam                                                                                                         | \$6,500 Ind<br>\$16,300 Fam | \$12,000 Ind<br>\$24,000 Fam | \$36,000 Ind<br>\$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<br>\$40 other PCP listed on ID card<br>\$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<br>\$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<br>(\$0 if lab test is performed and processed in doctor's office)                                                                                                  | \$40<br>(\$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<br>(copay waived with admission)                                                                                                                                    |                                                                         | \$600, then 30% after deductible<br>(copay waived with admission)                                                                   |                             |                              |                              |
| Inpatient Hospital          | Days 1-10: \$150/day<br>Days 11+: \$0                                                                                                                                    | Days 1-10: \$200/day<br>Days 11+: \$0                                   | \$750**                                                                                                                             | \$600, then 30% after ded   | \$1,500, then 30% after ded  | 50% after deductible         |

\*When enrolled in the 70/30 Plan, cost-sharing between you and the State Health Plan will vary. Medicare pays first. Then, the 70/30 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.

# 2027 STATE HEALTH PLAN COMPARISON

## MEDICARE PRIMARY Subscribers

| HUMANA MEDICARE ADVANTAGE & HUMANA PRESCRIPTION DRUG                                                                                  |                             |                                                        | 70/30 PPO Plan*                                |                           |                             |                      |
|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------|------------------------------------------------|---------------------------|-----------------------------|----------------------|
| 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<br>Days 21-100: \$50/day                                                                                               |                             |                                                        | 30% after deductible                           |                           |                             |                      |
| 20% coinsurance                                                                                                                       |                             |                                                        | 30% after deductible                           |                           |                             |                      |
| Included                                                                                                                              |                             |                                                        | N/A                                            |                           |                             |                      |
| PHARMACY BENEFITS                                                                                                                     |                             |                                                        |                                                |                           |                             |                      |
| \$2,400 Individual<br>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                               |                                                |                           |                             |                      |

\*When enrolled in the 70/30 Plan, cost-sharing between you and the State Health Plan will vary. Medicare pays first. Then, the 70/30 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.