2021 New CHP Medicare Advantage Medical Plan

Insured by Humana, Inc. and Administered by AmWINS

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Annual deductible	$50 combined in and out of network	
Annual medical out-of-pocket maximum	$500* combined in and out of network	
Annual plan maximum	Unlimited	

Covered Medical and Hospital Benefits

In general, this covers hospital care, outpatient care, including skilled nursing care (even if received in a nursing home), and most health services.

	ADVANTAGE OPTION You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Inpatient Hospital Care Our plan covers an unlimited number of days for an inpatient hospital state. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital	$0 per admit after deductible	
Outpatient Hospital Coverage Outpatient hospital visits Ambulatory surgical center	$0 to $100 copay after deductible $50 copay after deductible	
Doctor Office Visits Primary Care Provider (PCP) Specialists	$0 copay after deductible $10 copay after deductible	
Preventive Care Including: annual wellness visit, flu vaccine, colorectal cancer and breast cancer screenings, any approved Medicare preventive services.	Covered at no cost	$0 copay for Medicare-covered preventive services $0 copay for a supplemental annual physical exam
Emergency Care Emergency Room Ambulance	$50 copay after deductible (Medicare-covered) $25 copay after deductible	
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition requiring immediate attention	$0 to $25 copay after deductible	

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	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Diagnostic Radiology, Diagnostic Tests, and Outpatient X-Rays	$0 to $50 copay after deductible	
Lab Services	$0 copay after deductible	
Radiation Therapy	$10 to $50 copay after deductible	

Other Covered Medical and Hospital Benefits

In general, this covers hospital care, outpatient care, including skilled nursing care (even if received in a nursing home), and most health services.

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Skilled Nursing Facility Days 0 – 100 After day 100	$0 copay per day after deductible All costs	
Home Health Care	$0 copay after deductible	
Medical Equipment/Supplies **Diabetes Monitoring Supplies**	10% of the cost after deductible $0 copay or 10% of the cost after deductible	
Part B Prescription Drugs	10% of the cost after deductible	
Physical Therapy	$10 to $25 copay after deductible	
Rehabilitation Services Occupational/Speech Therapy Cardiac rehabilitation Pulmonary rehabilitation	$10 to $25 copay after deductible	

Mental Health and Substance Abuse Benefits

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Inpatient Inpatient hospital care limit applies to inpatient mental services. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	$0 per admit after deductible	
Outpatient group and individual therapy visits	$0 to $25 copay after deductible	
Outpatient group and individual substance abuse treatment visits	$0 to $25 copay after deductible	

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Other Medicare-Covered Services

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Hearing Services Medicare-covered hearing	$10 copay after deductible	
Dental Services Medicare-covered dental	$10 copay after deductible	
Vision Services Medicare-covered vision Medicare-covered diabetic eye exam Medicare-covered glaucoma screening Medicare covered eyewear (post-cataract)	$10 copay after deductible $0 copay after deductible $0 copay after deductible $10 copay after deductible	
Allergy Allergy shots & serum	$0 to $10 copay after deductible	
Chiropractic Services Medicare-covered chiropractic visit(s)	$10 copay after deductible	
Foot Care (Podiatry) Medicare-covered foot care	$10 copay after deductible	

Telehealth Services (In addition to traditional Medicare)

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Primary Care Provider (PCP)	$0 copay after deductible	Not covered
Specialist	$10 copay after deductible	Not covered
Urgent Care Services	$0 copay after deductible	Not covered
Substance Abuse or Behavioral Health Services	$0 copay after deductible	Not covered

Other benefits—not covered by Medicare

	ADVANTAGE OPTION In-Network You Pay+	ADVANTAGE OPTION Out-Of-Network You Pay+
Foreign travel emergency Foreign emergency outside of U.S.	20% coinsurance limited to emergency Medicare-covered services. $100 Deductible per year, $25,000 Maximum Benefit per year or 60 consecutive days,	

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Fitness & Wellness

***SilverSneakers* Fitness Program**	*SilverSneakers* Fitness Program – Basic fitness center membership including fitness classes

Included Medicare Part D prescription plan *(summaries are enclosed further in kit)*

Medicare Part D prescription coverage	Please see the Basic Option Prescription Coverage administered by Express Scripts on the following pages.

+ This plan options chart represents the amount you pay when the CHP Group Advantage Plan Option and Medicare are integrated to provide your coverage.

* Services that do not apply to the maximum out-of-pocket: Part D Pharmacy, Fitness Program, Health Education Services, Meal Benefit, Smoking Cessation (additional) and the Plan Premium (if applicable). If you reach the limit on out-of-pocket costs, Humana will pay the full cost for the rest of the year on covered hospital and medical services.

** In case of differences or errors in this summary of benefits, the Group Policy governs. You can see your plan's provider directory at **Humana.com** or call us at the number listed on the bottom of this page. Humana is a Medicare Advantage PPO plan with a Medicare Contract. Enrollment in this Humana plan depends on contract renewal.

Note: Some services may require prior authorization by Humana.

2021 CHP Medicare Basic Prescription Coverage

Administered by Express Scripts

Basic Option Prescription Coverage

Included with Medicare Advantage Option Only

Annual Deductible: $445

Copay tier	**Retail** (31 Days)		**Retail** (90 Days)		**Mail Order** (90 Days)
	Preferred	***Standard***	***Preferred***	***Standard***	***Preferred & Standard***
Preferred Generic tier	$5	$10	$15	$20	$5
Generic tier	$10	$15	$30	$35	$10
Preferred brand tier	20%	20% + $5	20%	20% + $5	20%
Non-preferred brand tier	45%	45% + $5	45%	45% + $5	45%
Specialty tier	25%	25% + $5	25%	25% + $5	25%
Coverage gap*:	**Same copay schedule as above for Generic Drugs. Members pay 25% for Brand & Specialty drugs.**				

*After your total yearly drug costs reach $4,130, you will pay the same copay schedule noted above for Generic Drugs. Member cost share on Brand and Specialty drugs will be 25% of the drug, the maximum allowable cost share as defined by CMS. The copays shown already include the manufacturer discounts on brand name drugs by the Medicare Coverage Gap Discount Program. The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving “Extra Help” through a low-income subsidy provided from Medicare. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap.

Catastrophic coverage begins once your total yearly out-of-pocket drug costs reach $6,550. In this stage, copays will be $3.70 for generic and preferred brand-name prescriptions and $9.20 for non-preferred brand name prescriptions or 5% of the cost of the drug, whichever is greater.

Prescription drug coverage is administered by Express Scripts, a Prescription Drug Plan (PDP) with a Medicare contract. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact AmWINS. Limitations, copayments and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Preferred Pharmacies: Allows a lower copay for your drugs. All CVS and 27,000+ other pharmacies are included.

Standard Pharmacies: Require a $5 higher copay for your drugs and include 64,000+ pharmacies nationwide.

To find a pharmacy near you, please visit www.Express-ScriptsMedicare.com