ANEJO 4

HUMANA HEALTH PLAN OF PR, INC.

RUBI MAX

HUMANA MEDICARE EMPLOYER HMO PLAN

2022 HMO for ELA Plan 076 Option 938 - Puerto Rico Only - Rubi Max - Part B Buy-Down $65

Effective Date: 01/01/2022 - 12/31/2022

		2021	2022
Annual Maximum Out-of-Pocket		• In-Network: $1,500 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Dental Services (Routine), Vision Services (Routine) Extra Services and the Plan Premium).	• In-Network: $1,500 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Dental Services (Routine), Vision Services (Routine) Extra Services and the Plan Premium).
Annual Deductible		• In-Network: NONE • In-Network Exclusions: N/A	• In-Network: NONE • In-Network Exclusions: N/A
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100%	100%
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%
Specialist	• Office Visit	100%	100%
	• Advanced Imaging Services	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100%	100%
	• Diagnostic Colonoscopy	100%	100%
	• Podiatry Services (Medicare-covered)	100%	100%
	• Chiropractic Services (Medicare-covered)	100%	100%
	• Cardiac Therapy	100%	100%
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%
	• Pulmonary Therapy	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%
	• Radiation Therapy	100%	100%
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Opioid Treatment Services	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%
	• Chemotherapy Drugs	100%	100%
	• Dental Services (Medicare-covered)	100%	100%
	• Hearing Services (Medicare-covered)	100%	100%
	• Vision Services (Medicare-covered)	100%	100%
	• Eyewear for Post-Cataract Surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%
	• Acupuncture (Medicare-covered) -Limited to 20 visit(s) per year - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	100%	100%
Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening	100%	100%

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	• Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit		
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% per admission	100% per admission
	• Inpatient Physician Services	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission	100% per admission
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100%	100%
	• Opioid Treatment Services	100%	100%
Outpatient Hospital	• Surgical Services	100%	100%
	• Diagnostic Colonoscopy	100%	100%
	• Advanced Imaging Services	100%	100%
	• Nuclear Medicine Services	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Radiation Therapy	100%	100%
	• Cardiac Therapy	100%	100%
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%
	• Pulmonary Therapy	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%
	• Chemotherapy Drugs	100%	100%
	• Renal Dialysis Services	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Opioid Treatment Services	100%	100%
	• Outpatient Physician Services	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%
Urgent Care Center	• Urgently Needed Care	100%	100%
	• Lab Services	100%	100%
Emergency Room	• Emergency Services (2)	100% after $15 copayment • Waived if admitted within 24 hours	100% after $15 copayment • Waived if admitted within 24 hours
	• Emergency Room Physician Services	100%	100%
Ambulance	• Ambulance Services	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	100% after $15 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services	100% after $15 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%
Freestanding Radiological Facility	• Advanced Imaging Services	100%	100%
	• Nuclear Medicine Services	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Radiation Therapy	100%	100%
Ambulatory Surgical Center	• Surgical Procedures	100%	100%
	• Diagnostic Colonoscopy	100%	100%
Freestanding Laboratory	• Lab Services	100%	100%
Dialysis Center	• Renal Dialysis Services	100%	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	100%	100%
	• Diabetic Monitoring Supplies	100%	100%
Medical Supply Provider	• Medical Supplies	100%	100%
Prosthetics Provider	• Prosthetics	100%	100%

ADMINISTRACION DE SEGUROS DE SALUD
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Pharmacy (Part B Only)	• Durable Medical Equipment	100%	100%
	• Medical Supplies	100%	100%
	• Diabetic Monitoring Supplies	100%	100%
	• Medicare-covered Part B Drugs	100%	100%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	100%
	• Specialist - Virtual Visit	100%	100%
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	100%
	• Urgently Needed Care - Virtual Visit	100%	100%
Other Benefits	• COVID-19 Testing and Treatment	100%	100%
	• Acupuncture Services (Routine)	•100% • Limited to 6 visit(s) per year	•100% • Limited to 6 visit(s) per year
	• Bathroom Safety Devises	•100% for bath chairs up to 1 every 5 years. •Provided to members who meet medical criteria. - BCS001	•100% for bath chairs up to 1 every 5 years. •Provided to members who meet medical criteria. - BCS001
	• Blood Pressure Monitor	•100% for blood pressure monitoring unit up to 1 every 5 years. •Provided to members who meet medical criteria for ongoing monitoring of blood pressure. - BPM001	•100% for blood pressure monitoring unit up to 1 every 5 years. •Provided to members who meet medical criteria for ongoing monitoring of blood pressure. - BPM001
	• Chiropractic Services (Routine)	•100% • Limited to 15 visit(s) per year	•100% • Limited to 15 visit(s) per year
	• Dental Services (Routine)	•100% for bitewing x-rays up to 1 set(s) every 2 years. •100% for scaling and root planing (deep cleaning) up to 1 every 2 years. •100% for amalgam or composite filling up to 1 per tooth every 3 years. •100% for comprehensive oral exam, panoramic film up to 1 every 3 years. •100% for crown up to 1 per tooth every 5 years. •100% for dentures up to 1 set(s) every 5 years. •100% for oral evaluation, prophylaxis (cleaning) up to 2 per year. •100% for endodontics up to unlimited per year. •100% for extractions up to 1 per tooth . - DEN945	•100% for bitewing x-rays up to 1 set(s) every 2 years. •100% for scaling and root planing (deep cleaning) up to 1 every 2 years. •100% for amalgam or composite filling up to 1 per tooth every 3 years. •100% for comprehensive oral exam, panoramic film up to 1 every 3 years. •100% for crown up to 1 per tooth every 5 years. •100% for dentures up to 1 set(s) every 5 years. •100% for oral evaluation, prophylaxis (cleaning) up to 2 per year. •100% for endodontics up to unlimited per year. •100% for extractions up to 1 per tooth . - DEN945
	• Hearing Services (Routine)	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$1,000 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. - HER865	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$1,000 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. - HER865
	• Over-the-Counter Drugs	•$200 maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers. - OTC203	•$200 maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) card to purchase eligible OTC health and wellness products at participating retailers. - OTC203
	• Transportation (Routine)	•100% for plan approved location up to 24 one-way trip(s) per year by taxi, van. - TRN022	•100% for plan approved location up to unlimited one-way trip(s) per year by car, van, wheelchair access vehicle. - TRNTBD
	• Vision Services (Routine)	•100% for routine exam (includes refraction) up to 1 per year. •$600 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglasses include ultraviolet protection and scratch resistant coating. - VIS212	•100% for routine exam up to 1 per year. •$1,000 maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglasses include ultraviolet protection and scratch resistant coating. - VISTBD

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.

Extra Benefits (MSB)	• SilverSneakers®	Available	Available
	• Personal Health Coaching	Available	Available
	• Health Essentials Kit	Available	Not Available
	• Smoking Cessation (Additional)	Available	Available
	• Meal Program	Available	Available
	• Special Supplemental Benefits for the Chronically Ill - (Non-Medical Transportation for 24 one-way trips)	Not Available	Available
	• Post-Discharge Transportation	Not Available	Available
	• Post-Discharge Personal Home Care	Not Available	Available
Care Management	• **Clinical Programs/Disease Management** (3) *- Case Management* *- Humana at Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Available	Available

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.

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The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Available	Available
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Available	Available
	• Dental Discount (Careington Dental) - Available in Florida only	Available	Available
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Available	Available
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Available	Available
	• Lifeline® Medical Alert Systems	Available	Available
	• Meal Delivery Discount	Available	Available
	• Vision Discount (EyeMed)	Available	Available
	• Go365 by Humana (Rock and Roll Marathon Series)	Available	Available
	• Weight Management Discount (Jenny Craig®)	Available	Not Available

Go365® by Humana is included in this plan

Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Members residing in some states can get coverage for most services without a referral or approval ahead of time from their PCP. 'Self-referred' means members get services on their own from network specialists. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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HUMANA MEDICARE EMPLOYER Rx PLAN

2022 Rx for ELA Rx 143 - Puerto Rico Only - Rubi Max

Group Select Formulary

With Package(s): 6 (Erectile Dysfunction)

Effective Date: 01/01/2022 - 12/31/2022

30 day Supplies

Plan/ Option	30 day Standard Retail from $0 to ICL (1)				30 day Standard Retail from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/938	$0	$0	$3	25%	$0	25% For Generic and Brand Drugs			Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$3	25%

Plan/ Option	30 day Standard Mail Order from $0 to ICL (1)				30 day Standard Mail Order from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/938	$0	$0	$3	25%	$0	25% For Generic and Brand Drugs			Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$3	25%

**** Member pays $0 for Insulin.**

*Tier 1: Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.

Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.

Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offered at a higher cost than Tier 2 Preferred Brand drugs

Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

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90 day Supplies

Plan/ Option	90 day Standard Retail (4) from $0 to ICL (1)				90 day Standard Retail (4) from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Retail (4) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/938	$0	$0	$6	N/A	$0	25% For Generic and Brand Drugs		N/A	Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$6	N/A

Plan/ Option	90 day Standard Mail Order (4) from $0 to ICL (1)				90 day Standard Mail Order (4) from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Mail Order (4) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/938	$0	$0	$6	N/A	$0	25% For Generic and Brand Drugs		N/A	Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$6	N/A

** Member pays $0 for Insulin.

Footnotes

1 ICL (Initial Coverage Limit): When total drug cost (the amount the member pays plus the amount Humana pays) reaches $4,430.
2 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,050.
3 Home Infusion Drugs: After the deductible has been met, these drugs will be covered at the specified cost shares in the Coverage Gap.
4 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:
a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,
b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price.

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Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card. CMS does not permit discussing the below services with potential enrollees prior to enrollment.

• Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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ANEJO 4

HUMANA HEALTH PLAN OF PR, INC.

ZAFIRO

HUMANA MEDICARE EMPLOYER HMO PLAN

2022 HMO for ELA Plan 076 Option 654 - Puerto Rico Only - Zafiro - Part B Buy-Down $100

Effective Date: 01/01/2022 - 12/31/2022

		2021	2022
Annual Maximum Out-of-Pocket		• In-Network: $1500 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Dental Services (Routine), Vision Services (Routine), Extra Services and the Plan Premium).	• In-Network: $1500 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Dental Services (Routine), Vision Services (Routine), Extra Services and the Plan Premium).
Annual Deductible		• In-Network: NONE • In-Network Exclusions: N/A	• In-Network: NONE • In-Network Exclusions: N/A
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100%	100%
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%
Specialist	• Office Visit	100% after $3 copayment	100%
	• Advanced Imaging Services	100% after $3 copayment	100%
	• Diagnostic Procedures and Tests	100% after $3 copayment	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100% after $3 copayment	100%
	• Diagnostic Colonoscopy	100% after $3 copayment	100%
	• Podiatry Services (Medicare-covered)	100% after $3 copayment	100%
	• Chiropractic Services (Medicare-covered)	100% after $3 copayment	100%
	• Cardiac Therapy	100% after $3 copayment	100%
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100% after $3 copayment	100%
	• Pulmonary Therapy	100% after $3 copayment	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $3 copayment	100%
	• Radiation Therapy	100% after $3 copayment	100%
	• Allergy Shots and Injections	100% after $3 copayment	100%
	• Mental Health/Substance Abuse Services	100% after $3 copayment	100%
	• Opioid Treatment Services	100% after $3 copayment	100%
	• Administration of Drugs in a Physician's Office	100%	100%
	• Chemotherapy Drugs	100%	100%
	• Dental Services (Medicare-covered)	100% after $3 copayment	100%
	• Hearing Services (Medicare-covered)	100% after $3 copayment	100%
	• Vision Services (Medicare-covered)	100% after $3 copayment	100%
	• Eyewear for Post-Cataract Surgery	100% after $3 copayment •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%
	• Acupuncture (Medicare-covered) -Limited to 20 visit(s) per year - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	100% after $3 copayment	100%
Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening	100%	100%

ADMINISTRACION DE SEGUROS DE SALUD
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	• Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit		
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% after $25 copayment per admission	100% per admission
	• Inpatient Physician Services	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% after $25 copayment per admission	100% per admission
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% after $25 copayment per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100% after $25 copayment	100%
	• Opioid Treatment Services	100% after $25 copayment	100%
Outpatient Hospital	• Surgical Services	100% after $15 copayment	100% after $15 copayment
	• Diagnostic Colonoscopy	100% after $15 copayment	100% after $15 copayment
	• Advanced Imaging Services	100% after $7 copayment	100%
	• Nuclear Medicine Services	100% after $7 copayment	100% after $7 copayment
	• Diagnostic Procedures and Tests	100% after $7 copayment	100% after $7 copayment
	• Lab Services	100%	100%
	• Radiation Therapy	100% after $7 copayment	100% after $7 copayment
	• Cardiac Therapy	100% after $15 copayment	100% after $15 copayment
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after $15 copayment	100% after $15 copayment
	• Pulmonary Therapy	100% after $15 copayment	100% after $15 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $15 copayment	100% after $15 copayment
	• Chemotherapy Drugs	100%	100%
	• Renal Dialysis Services	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Opioid Treatment Services	100%	100%
	• Outpatient Physician Services	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%
Urgent Care Center	• Urgently Needed Care	100%	100%
	• Lab Services	100%	100%
Emergency Room	• Emergency Services (2)	100% after $25 copayment • Waived if admitted within 24 hours	100% after $20 copayment • Waived if admitted within 24 hours
	• Emergency Room Physician Services	100%	100%
Ambulance	• Ambulance Services	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	100% after $25 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services	100% after $25 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100% after $3 copayment	100% after $3 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $3 copayment	100% after $3 copayment
Freestanding Radiological Facility	• Advanced Imaging Services	100% after $7 copayment	100%
	• Nuclear Medicine Services	100% after $7 copayment	100% after $7 copayment
	• Diagnostic Procedures and Tests	100% after $7 copayment	100% after $7 copayment
	• Radiation Therapy	100% after $7 copayment	100% after $7 copayment
Ambulatory Surgical Center	• Surgical Procedures	100% after $15 copayment	100% after $15 copayment
	• Diagnostic Colonoscopy	100% after $15 copayment	100% after $15 copayment
Freestanding Laboratory	• Lab Services	100%	100%
Dialysis Center	• Renal Dialysis Services	100%	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	100%	100%
	• Diabetic Monitoring Supplies	100%	100%
Medical Supply Provider	• Medical Supplies	100%	100%
Prosthetics Provider	• Prosthetics	100%	100%

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Pharmacy (Part B Only)	• Durable Medical Equipment	100%	100%
	• Medical Supplies	100%	100%
	• Diabetic Monitoring Supplies	100%	100%
	• Medicare-covered Part B Drugs	100%	100%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	100%
	• Specialist - Virtual Visit	100% after $3 copayment	100% after $3 copayment
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	100%
	• Urgently Needed Care - Virtual Visit	100%	100%
Other Benefits	• COVID-19 Testing and Treatment	100%	100%
	• Acupuncture Services (Routine)	•100% • Limited to 6 visit(s) per year	•100% • Limited to 6 visit(s) per year
	• Bathroom Safety Devices - BCS001	•100% for bath chairs up to 1 every 5 years. •Provided to members who meet medical criteria.	•100% for bath chairs up to 1 every 5 years. •Provided to members who meet medical criteria.
	• Chiropractic Services (Routine)	•100% • Limited to 15 visit(s) per year	•100% • Limited to 15 visit(s) per year
	• Blood Pressure Monitor - BPM001	•100% for a blood pressure monitoring unit up to 1 every 5 years. •Provided to members who meet medical criteria for ongoing monitoring of blood pressure.	•100% for a blood pressure monitoring unit up to 1 every 5 years. •Provided to members who meet medical criteria for ongoing monitoring of blood pressure.
	• Dental Services (Routine)	•100% for bitewing x-rays up to 1 set(s) every 2 years. •100% for amalgam or composite filling up to 1 per tooth every 3 years. •100% for comprehensive oral exam, panoramic film up to 1 every 3 years. •100% for scaling and root planing (deep cleaning) up to 1 per quadrant per year. •100% for periodontal debridement up to 1 per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. •100% for intraoral x-rays up to 6 per year. •100% for extractions up to unlimited per year. •75% for crown up to 1 per tooth every 5 years. •75% for bridges, complete dentures, partial dentures up to 1 every 5 years. •75% for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. •75% for adjustments to dentures, root canal up to unlimited per year. •$1,500 maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures, other restorative services - core buildup and prefabricated post and core, bridges. - DEN520	•100% for bitewing x-rays up to 1 set(s) every 2 years. •100% for amalgam and/or composite filling up to 1 per tooth every 3 years. •100% for comprehensive oral exam, panoramic film up to 1 every 3 years. •100% for crown up to 1 per tooth every 5 years. •100% for bridges, complete dentures, partial dentures up to 1 every 5 years. •100% for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. •100% for scaling and root planing (deep cleaning) up to 1 per quadrant per year. •100% for periodontal debridement up to 1 per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. 100% for intraoral x-rays up to 6 per year. •100% for adjustments to dentures, extractions, root canal up to unlimited per year. •$5000 maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures, other restorative services - core buildup and prefabricated post and core, bridges. - DENTBD
	• Hearing Services (Routine)	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$250 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. - HER727	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$500 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. - HERTBD
	• Over-the-Counter Drugs	•$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. - OTC062	•$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. - OTC062
	• Transportation (Routine)	•100% for plan approved location up to 12 one-way trip(s) per year by taxi, van. - TRN236	•100% for plan approved location up to 24 one-way trip(s) per year by car, van, wheelchair access vehicle. - TRNTBD
	• Vision Services (Routine)	•100% for routine exam (includes refraction) up to 1 per year. •$400 maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames. - VIS203	•100% for routine exam up to 1 per year. •$850 maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglasses include ultraviolet protection and scratch resistant coating. - VISTBD

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.			
Extra Benefits (MSB)	• SilverSneakers®	Available	Available
	• Personal Health Coaching	Available	Available
	• Health Essentials Kit	Available	Not Available
	• Smoking Cessation (Additional)	Available	Available
	• Meal Program	Available	Available
	• Post-Discharge Transportation	Not Available	Available
	• Post-Discharge Personal Home Care	Not Available	Available
Care Management	• **Clinical Programs/Disease Management (3)** - *Case Management* - *Humana at Home®* - *Chronic Condition Management* - *Transplant Management* - *Behavioral Health Care Coordination*	Available	Available

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.

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The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Available	Available
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Available	Available
	• Dental Discount (Carelington Dental) - Available in Florida only	Available	Available
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Available	Available
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Available	Available
	• Lifeline® Medical Alert Systems	Available	Available
	• Meal Delivery Discount	Available	Available
	• Vision Discount (EyeMed)	Available	Available
	• Go365 by Humana (Rock and Roll Marathon Series)	Available	Available
	• Weight Management Discount (Jenny Craig®)	Available	Not Available

Go365® by Humana is included in this plan

Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Members residing in some states can get coverage for most services without a referral or approval ahead of time from their PCP. 'Self-referred' means members get services on their own from network specialists. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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Humana
Group Medicare Advantage

HUMANA MEDICARE EMPLOYER Rx PLAN

2022 Rx for ELA Rx 419 - Puerto Rico Only - Zafiro
Group Select Formulary
With Package(s): 6 (Erectile Dysfunction)
Effective Date: 01/01/2022 - 12/31/2022

30 day Supplies

Plan/ Option	30 Day Standard Retail from $0 to ICL (1)				30 Day Standard Retail from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/654	$0	$0	$10	25%	$0	25% - For Generic and Brand Drugs			Member pays the greater of $3.95 for generic/preferred multi-source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$10	25%

Plan/ Option	30 Day Standard Mail from $0 to ICL (1)				30 Day Standard Mail Order from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/654	$0	$0	$10	25%	$0	25% - For Generic and Brand Drugs			Member pays the greater of $3.95 for generic/preferred multi-source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$10	25%

** Member pays $0 for Insulin.
*Tier 1: Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offered at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

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90 day Supplies

Plan/ Option	90 Day Standard Retail (4) from $0 to ICL (1)				90 Day Standard Retail from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Retail (3) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/654	$0	$0	$20	N/A	$0	25% - For Generic and Brand Drugs		N/A	Member pays the greater of $3.95 for generic/preferred multi-source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$20	N/A

Plan/ Option	90 Day Standard Mail Order (4) from $0 to ICL (1)				90 Day Standard Mail Order from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Mail Order (3) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/654	$0	$0	$20	N/A	$0	25% - For Generic and Brand Drugs		N/A	Member pays the greater of $3.95 for generic/preferred multi-source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$20	N/A

** Member pays $0 for Insulin.

Footnotes

1 ICL (Initial Coverage Limit): When total drug cost (the amount the member pays plus the amount Humana pays) reaches $4,430
2 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,050.
3 Home Infusion Drugs: After the deductible has been met, these drugs will be covered at the specified cost shares in the Coverage Gap.
4 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:
a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,
b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price.

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Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

• Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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ANEJO 4

HUMANA HEALTH PLAN OF PR, INC.

BASIC DELUXE

HUMANA MEDICARE EMPLOYER HMO PLAN

2022 HMO for ELA Plan 076 Option 251 - Puerto Rico Only - Basic Deluxe - Part B Buy-Down $148.50

Effective Date: 01/01/2022 - 12/31/2022

		2021	2022
Annual Maximum Out-of-Pocket		• In-Network: $6,700 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Extra Services and the Plan Premium).	• In-Network: $6,700 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Extra Services and the Plan Premium).
Annual Deductible		• In-Network: NONE • In-Network Exclusions: N/A	• In-Network: NONE • In-Network Exclusions: N/A
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	95%	95%
	• Surgical Procedures	100%	100%
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%
Specialist	• Office Visit	100% after $7 copayment	100% after $7 copayment
	• Advanced Imaging Services	90% • up to $65 maximum out of pocket per visit	90% • up to $65 maximum out of pocket per visit
	• Diagnostic Procedures and Tests	100% after $7 copayment	100% after $7 copayment
	• Lab Services	95%	95%
	• Surgical Procedures	100% after $7 copayment	100% after $7 copayment
	• Diagnostic Colonoscopy	100% after $7 copayment	100% after $7 copayment
	• Podiatry Services (Medicare-covered)	100% after $7 copayment	100% after $7 copayment
	• Chiropractic Services (Medicare-covered)	100% after $7 copayment	100% after $7 copayment
	• Cardiac Therapy	100% after $7 copayment	100% after $7 copayment
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100% after $7 copayment	100% after $7 copayment
	• Pulmonary Therapy	100% after $7 copayment	100% after $7 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $7 copayment	100% after $7 copayment
	• Radiation Therapy	100% after $7 copayment	100% after $7 copayment
	• Allergy Shots and Injections	100% after $7 copayment	100% after $7 copayment
	• Mental Health/Substance Abuse Services	100% after $7 copayment	100% after $7 copayment
	• Opioid Treatment Services	100% after $7 copayment	100% after $7 copayment
	• Administration of Drugs in a Physician's Office	100%	100%
	• Chemotherapy Drugs	100%	100%
	• Dental Services (Medicare-covered)	100% after $7 copayment	100% after $7 copayment
	• Hearing Services (Medicare-covered)	100% after $7 copayment	100% after $7 copayment
	• Vision Services (Medicare-covered)	100% after $7 copayment	100% after $7 copayment
	• Eyewear for Post-Cataract Surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%
	• Acupuncture (Medicare-covered) - Limited to 20 visit(s) per year - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	100% after $7 copayment	100% after $7 copayment
Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening	100%	100%

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	• Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit		
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% after $25 copayment per admission	100% after $50 copayment per admission
	• Inpatient Physician Services	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission	100% after $50 copayment per admission
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission •190 day lifetime limit in a psychiatric facility	100% after $50 copayment per admission •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100%	100%
	• Opioid Treatment Services	100%	100%
Outpatient Hospital	• Surgical Services	100% after $25 copayment	100% after $25 copayment
	• Diagnostic Colonoscopy	100% after $25 copayment	100% after $25 copayment
	• Advanced Imaging Services	90% • up to $65 maximum out of pocket per visit	90% • up to $65 maximum out of pocket per visit
	• Nuclear Medicine Services	90% • up to $65 maximum out of pocket per visit	90% • up to $65 maximum out of pocket per visit
	• Diagnostic Procedures and Tests	80%	80%
	• Lab Services	95%	95%
	• Radiation Therapy	100% after $7 copayment	100% after $7 copayment
	• Cardiac Therapy	100% after $7 copayment	100% after $7 copayment
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after $7 copayment	100% after $7 copayment
	• Pulmonary Therapy	100% after $7 copayment	100% after $7 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $7 copayment	100% after $7 copayment
	• Chemotherapy Drugs	100%	100%
	• Renal Dialysis Services	100%	100%
	• Mental Health/Substance Abuse Services	100% after $7 copayment	100% after $7 copayment
	• Opioid Treatment Services	100% after $7 copayment	100% after $7 copayment
	• Outpatient Physician Services	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%
Urgent Care Center	• Urgently Needed Care	100%	100%
	• Lab Services	95%	95%
Emergency Room	• Emergency Services (2)	100% after $50 copayment • Waived if admitted within 24 hours	100% after $50 copayment • Waived if admitted within 24 hours
	• Emergency Room Physician Services	100%	100%
Ambulance	• Ambulance Services	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	100% after $50 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services	100% after $50 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100% after $7 copayment	100% after $7 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $7 copayment	100% after $7 copayment
Freestanding Radiological Facility	• Advanced Imaging Services	90% • up to $65 maximum out of pocket per visit	90% • up to $65 maximum out of pocket per visit
	• Nuclear Medicine Services	90% • up to $65 maximum out of pocket per visit	90% • up to $65 maximum out of pocket per visit
	• Diagnostic Procedures and Tests	80%	80%
	• Radiation Therapy	100% after $7 copayment	100% after $7 copayment
Ambulatory Surgical Center	• Surgical Procedures	100% after $25 copayment	100% after $25 copayment
	• Diagnostic Colonoscopy	100% after $25 copayment	100% after $25 copayment
Freestanding Laboratory	• Lab Services	95%	95%
Dialysis Center	• Renal Dialysis Services	100%	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	80%	80%
	• Diabetic Monitoring Supplies	80%	80%
Medical Supply Provider	• Medical Supplies	100%	100%
Prosthetics Provider	• Prosthetics	80%	80%

Pharmacy (Part B Only)	• Durable Medical Equipment	100%	100%
	• Medical Supplies	100%	100%
	• Diabetic Monitoring Supplies	100%	100%
	• Medicare-covered Part B Drugs	100%	100%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	100%
	• Specialist - Virtual Visit	100% after $7 copayment	100% after $7 copayment
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	100%
	• Urgently Needed Care - Virtual Visit	100%	100%
Other Benefits	• COVID-19 Testing and Treatment	100%	100%
	• Acupuncture Services (Routine)	100% after $15 copayment • Limited to 6 visit(s) per year	100% after $15 copayment • Limited to 6 visit(s) per year
	• Chiropractic Services (Routine)	100% after $7 copayment • Limited to 15 visit(s) per year	100% after $7 copayment • Limited to 15 visit(s) per year
	• Dental Services (Routine)	•$1,000 maximum benefit coverage amount per year. •100% for bitewing x-rays, oral evaluation, sealants, prophylaxis (cleaning). •80% coinsurance for bridgework, crown, dentures, endodontics, extractions, filling, periodontics, implant, root canal. - DEN015	•100% for bitewing x-rays up to 1 set(s) every 2 years. •100% for amalgam and/or composite filling up to 1 per tooth every 3 years. •100% for comprehensive oral exam, panoramic film up to 1 every 3 years. •100% for crown up to 1 per tooth every 5 years. •100% for bridges, complete dentures, partial dentures up to 1 every 5 years. •100% for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. •100% for scaling and root planing (deep cleaning) up to 1 per quadrant per year. •100% for periodontal debridement up to 1 per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. •100% for intraoral x-rays up to 6 per year. •100% for adjustments to dentures, extractions, root canal up to unlimited per year. •$1,500 maximum benefit coverage amount per year for adjustments to dentures, complete dentures, crown, partial dentures, other restorative services - core buildup and prefabricated post and core, bridges. - DENTBD
	• Hearing Services (Routine)	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$400 maximum benefit coverage amount for hearing aids (all types) up to 2 every 3 years. - HER008	•100% for fitting/evaluation, routine hearing exams up to 1 per year. •$400 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. - HERTBD
	• Transportation (Routine)	Not Available	•100% for plan approved location up to 24 one-way trip(s) per year by car, van, wheelchair access vehicle. - TRNTBD
	• Vision Services (Routine)	•100% for routine exam (includes refraction) up to 1 per year. •$200 maximum benefit coverage amount every 2 years for contact lenses, eyeglasses-lenses and frames. - VIS772	•100% for routine exam up to 1 per year. •$400 maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglasses include ultraviolet protection and scratch resistant coating. - VISTBD

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.			
Extra Benefits (MSB)	• SilverSneakers®	Available	Available
	• Personal Health Coaching	Available	Available
	• Health Essentials Kit	Available	Not Available
	• Smoking Cessation (Additional)	Available	Available
	• Meal Program	Available	Available
	• Post-Discharge Transportation	Not Available	Available
	• Post-Discharge Personal Home Care	Not Available	Available
Care Management	• **Clinical Programs/Disease Management (3)** *- Case Management* *- Humana at Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Available	Available

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.

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The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Lifeline® Medical Alert Systems	Available	Available
	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Available	Available
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Available	Available
	• Dental Discount (Careington Dental) - Available in Florida only	Available	Available
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Available	Available
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Available	Available
	• Meal Delivery Discount	Available	Available
	• Vision Discount (EyeMed)	Available	Available
	• Go365 by Humana (Rock and Roll Marathon Series)	Available	Available
	• Weight Management Discount (Jenny Craig®)	Available	Not Available

Go365® by Humana is included in this plan

Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Members residing in some states can get coverage for most services without a referral or approval ahead of time from their PCP. 'Self-referred' means members get services on their own from network specialists. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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HUMANA MEDICARE EMPLOYER Rx PLAN

2022 Rx for ELA Rx 170 - Puerto Rico Only - Basic Deluxe
Group Select Formulary
Effective Date: 01/01/2022 - 12/31/2022

30 day Supplies

Plan/ Option	30 day Standard Retail from $0 to ICL (1)				30 day Standard Retail from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/251	$0	$0	$12	25%	25% - For Generic and Brand Drugs				Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$12	25%

Plan/ Option	30 day Standard Mail Order from $0 to ICL (1)				30 day Standard Mail Order from ICL to Catastrophic (2) "Coverage Gap"				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	30 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/251	$0	$0	$12	25%	25% - For Generic and Brand Drugs				Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$12	25%

**** Member pays $0 for insulin.**
*Tier 1: Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offered at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

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90 day Supplies

Plan/ Option	90 day Standard Retail (4) from $0 to ICL (1)				90 day Standard Retail (4) from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Retail (4) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Retail Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/251	$0	$0	$36	N/A	25% - For Generic and Brand Drugs			N/A	Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$36	N/A

Plan/ Option	90 day Standard Mail Order (4) from $0 to ICL (1)				90 day Standard Mail Order (4) from ICL to Catastrophic (2) "Coverage Gap"				90 day Standard Mail Order (4) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic	90 day Standard Mail Order Home Infusion Drugs (3)			
	Tier 1*	Tier 2	Tier 3	Tier 4	Tier 1*	Tier 2	Tier 3	Tier 4			Tier 1*	Tier 2	Tier 3	Tier 4
076/251	$0	$0	$24	N/A	25% - For Generic and Brand Drugs			N/A	Member pays the greater of $3.95 for generic/preferred multi source drugs/biosimilars and $9.85 for all other drugs; OR 5% coinsurance.	$7,050	$0	$0	$24	N/A

** Member pays $0 for insulin.

Footnotes

1 ICL (Initial Coverage Limit): When total drug cost (the amount the member pays plus the amount Humana pays) reaches $4,430.

2 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,050.

3 Home Infusion Drugs: After the deductible has been met, these drugs will be covered at the specified cost shares in the Coverage Gap.

4 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:

a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,

b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price.

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Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card. CMS does not permit discussing the below services with potential enrollees prior to enrollment.

- Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.