

2025 STATE HEALTH PLAN COMPARISON

Medicare Primary Subscribers

PLAN DESIGN FEATURES	Humana® GROUP MEDICARE (90/10)**		Base PPO Plan (70/30)*
	BASE PLAN	ENHANCED PLAN	
Use of Network Providers	You can see any provider (in-network or out-of-network) that participates in Medicare, accepts your insurance and preferably accepts Medicare assignment. Your copays or coinsurance stay the same.		You pay less when you use Aetna network providers.
Annual Deductible	\$0		Individual: \$1,500 in-network; \$3,000 out-of-network Family: \$4,500 in-network; \$9,000 out-of-network (includes medical and pharmacy deductible)
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%).		In-network: 30% of eligible expenses after deductible Out-of-network: 50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Annual Out-of-Pocket Maximum	\$4,000 Individual No Family Maximum (This is a medical maximum out-of-pocket limit and includes medical copays/coinsurance)	\$3,300 Individual No Family Maximum (This is a medical maximum out-of-pocket limit and includes medical copays/coinsurance)	Individual: \$5,900 in-network; \$11,800 out-of-network Family: \$16,300 in-network; \$32,600 out-of-network (includes medical & pharmacy)
Preventive Services	\$0 (may be charged a copay if other services are provided and billed during visit).		In-network: \$0 (covered at 100%)
Office Visits	\$20 for PCP; \$40 for Specialist	\$10 for PCP; \$35 for Specialist	In-network: \$0 for CPP PCP on ID card; \$30 for non-CPP PCP on ID card; \$45 other PCP; \$47 for CPP Specialist; \$94 for Non-CPP Specialist
Teledoc	N/A		\$45
Lab Services	\$40 copay; if lab test performed and processed in doctor's office, \$0 copay	\$10 copay; if lab test is performed and processed in doctor's office, \$0 copay	In-network: 30% coinsurance, Out-of-network: 50% coinsurance; If performed during PCP or Specialist office visit, no additional fee if in-network lab used.

* When enrolled in the 70/30 Plan, cost-sharing amounts between you and the State Health Plan will vary. Medicare pays benefits first. Then, the 70/30 Plan may help pay some of the costs that Medicare does not cover.

PCP: Primary Care Provider, CPP: Clear Pricing Project

To find a CPP Provider, visit www.shpnc.org and click Find a Doctor.

PLAN DESIGN FEATURES	Humana® GROUP MEDICARE (90/10)**		Base PPO Plan (70/30)*
	BASE PLAN	ENHANCED PLAN	
Urgent Care	\$50	\$40	\$100
Emergency Room (Copay waived w/admission or observation stay)	\$65		In-network: \$337 copay plus 30% coinsurance after deductible is met
Inpatient Hospital	Days 1-10: \$160/day Days 11+: \$0	Days 1-10: \$125/day Days 11+: \$0	In-network: \$337 copay plus 30% coinsurance after deductible is met
Outpatient Hospital	\$125	\$100	In-network: 30% coinsurance after deductible is met
Outpatient Surgery - Ambulatory Surgical Center	\$250		In-network: 30% coinsurance after deductible is met
Diagnostic (e.g., CT, MRI)	\$100		In-network: 30% coinsurance after deductible is met
Skilled Nursing Facility	Days 1-20: \$0 Days 21-100: \$50/day		In-network: 30% coinsurance after deductible is met
Chiropractic Visits	\$20		In-network: \$36 for CPP Providers; \$72 for other Providers
Durable Medical Equipment	20% coinsurance		In-network: 30% coinsurance after deductible is met
SilverSneakers® Fitness Program	Included		Not covered

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** The Humana Group Medicare Advantage Plans have a benefit value equivalent of a 90/10 plan.

Pharmacy Benefits

PLAN DESIGN FEATURES	Humana® GROUP MEDICARE (90/10)***		Base PPO Plan (70/30)*
	BASE PLAN	ENHANCED PLAN	
Pharmacy Out-of- Pocket Maximum	\$2,000 Individual No Family Maximum		N/A
RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER			
Tier 1	\$10 copay per 30-day supply		\$16 copay per 30-day supply
Tier 2	\$40 copay per 30-day supply		\$47 copay per 30-day supply
Tier 3	\$64 copay per 30-day supply	\$50 copay per 30-day supply	Deductible/coinsurance
Tier 4	25% coinsurance up to \$100 per 30-day supply		\$200 copay per 30-day supply
Tier 5	N/A		\$350 copay per 30-day supply
Tier 6	N/A		Deductible/coinsurance
Preferred Blood Glucose Meters (BGM) and Supplies	\$0 copay		\$10 copay per 30-day supply
Continuous Glucose Monitors (CGMs) and Supplies	\$0 copay for Medicare-covered therapeutic CGMs and supplies		CGMs and associated supplies are considered a Tier 2 member copay
Preferred and Non-Preferred Insulin	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 (up to a 30-day) supply.		\$0 copay per 30-day supply
MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY			
Tier 1	\$24 copay		\$48 copay
Tier 2	\$80 copay		\$141 copay
Tier 3	\$128 copay	\$100 copay	Deductible/coinsurance
Tier 4**	25% coinsurance up to \$300	25% coinsurance up to \$200	\$600
Tier 5	N/A		\$1,050
Tier 6	N/A		Deductible/coinsurance

* This does not include Continuous Glucose Monitoring Systems or associated supplies. Preferred Continuous Glucose Monitoring Systems and associated supplies are considered a Tier 2 member copay.

** Some specialty drugs are limited to a 30-day supply (depending on the plan).

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