

Illinois 80/50 Plan

| | | Plan pays for services from PARTICIPATING providers | Plan pays for services from NONPARTICIPATING providers |
|---------------------------------------|--|--|--|
| Up-front benefit allowance | Member benefit applies to medical services received from participating providers only. Does not apply to member copayments, preventive care or pharmacy benefits. | \$500 per calendar year per member | Not applicable |
| Office visit copayment options | | <ul style="list-style-type: none"> \$20 primary care/\$40 specialist \$30 primary care/\$50 specialist | Not applicable |
| Deductible options | <ul style="list-style-type: none"> individual family | <ul style="list-style-type: none"> \$1,000/\$1,500/\$2,000/\$2,500 \$3,000/\$4,000/\$5,000 | Three times the individual participating deductible |
| | | <ul style="list-style-type: none"> \$2,000/\$3,000/\$4,000/\$5,000 \$6,000/\$8,000/\$10,000 | Three times the family participating deductible |
| Out-of-pocket maximum options | <ul style="list-style-type: none"> individual family | <ul style="list-style-type: none"> \$2,000/\$3,000/\$4,000 \$4,000/\$6,000/\$8,000 | Three times the individual participating out-of-pocket max |
| | | | Three times the family participating out-of-pocket max |
| Preventive care | <ul style="list-style-type: none"> preventive office visits preventive lab and X-ray Pap smear and mammogram prostate screening child immunizations to age 18 flu and pneumonia immunizations endoscopic services (including, but not limited to colonoscopy) | <ul style="list-style-type: none"> 100% after office visit copayment 100% 80% after deductible | <ul style="list-style-type: none"> 50% after deductible 50% after deductible 50% after deductible |
| Physician services | <ul style="list-style-type: none"> office visits diagnostic lab and X-ray allergy testing injections and serums (including allergy) inpatient and outpatient services surgery emergency room visits | <ul style="list-style-type: none"> 100% after office visit copayment and deductible 100% after deductible 100% after \$5 copayment per visit and deductible 80% after deductible 80% after deductible 80% after deductible | <ul style="list-style-type: none"> 50% after deductible 50% after deductible 50% after deductible 50% after deductible 80% after participating deductible |
| Facility services | <ul style="list-style-type: none"> inpatient services outpatient surgery outpatient services outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)—hospital, freestanding facility and clinic emergency services (copayment waived if admitted) | <ul style="list-style-type: none"> 80% after \$500 copayment per confinement and deductible 80% after \$100 copayment per visit and deductible 80% after deductible 80% after \$150 copayment per visit and deductible | <ul style="list-style-type: none"> 50% after \$500 copayment per confinement and deductible 50% after \$100 copayment per visit and deductible 50% after deductible 80% after \$150 copayment per visit and participating deductible |
| Other medical services | <ul style="list-style-type: none"> skilled nursing facility (up to 60 days per calendar year) hospice home health care (up to 100 visits per calendar year) physical, occupational, cognitive, speech and audiology therapy (combined limit up to 80 visits per calendar year) urgent care spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year) durable medical equipment (limited to \$2,500 of covered services per calendar year) ambulance maternity | <ul style="list-style-type: none"> 80% after deductible 100% after specialist copayment per visit and deductible 80% after deductible 80% after deductible 80% after deductible Same as any other illness | <ul style="list-style-type: none"> 50% after deductible 50% after deductible 50% after deductible 80% after participating deductible Same as any other illness |

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|--|---|--|---|
| Other medical services (continued) | <ul style="list-style-type: none"> transplant services | Same as any other illness when services are received from a Humana Transplant Network provider | Same as any other illness. Covered expenses are limited to a maximum benefit of \$35,000 per transplant |
| Lifetime maximum benefit | | | \$5,000,000 |
| Mental health and chemical dependency | <ul style="list-style-type: none"> inpatient services (combined mental health and chemical dependency limit up to 10 days per calendar year) | 80% after \$500 copayment per confinement and deductible | 50% after \$500 copayment per confinement and deductible |
| | <ul style="list-style-type: none"> outpatient and office therapy sessions (combined mental health and chemical dependency limit up to 15 visits per calendar year) | 80% after specialist copayment and participating deductible | 50% after deductible |
| Alcohol dependency services | <ul style="list-style-type: none"> inpatient services | Same as any other illness | Same as any other illness |
| | <ul style="list-style-type: none"> outpatient and office therapy sessions (combined limit up to 15 visits per calendar year) | Same as any other illness | Same as any other illness |

Network

☐ Humana ChoicePOS network

Humana's ChoicePOS Network is a local network of physicians and hospitals in the Chicago metropolitan area, and also includes access to Humana's ChoiceCare[®] Network. The ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, including 530,000 providers and 4,000 hospitals across all 50 states.

Pharmacy options

Detailed drug lists are available at Humana.com for each pharmacy plan and level.

Rx4

| Retail (30-day supply) | Level 1 | Level 2 | Level 3 | Level 4 |
|---|--------------------------------------|---------|---------|---------|
| › Option 1 | \$10 | \$30 | \$50 | 25% |
| › Option 2 | \$10 | \$35 | \$55 | 25% |
| › Option 3 | \$10 | \$40 | \$65 | 25% |
| Mail order (up to 90-day supply) | 2.5 times the retail copayment | | | |
| Copayment maximum (applies to Level 4 drugs only) | \$2,500 per member per calendar year | | | |

NOTE: If a nonparticipating pharmacy is used, the claim will be covered at 70 percent after applicable copayment.

Rx3

| Retail (30-day supply) | Level 1 | Level 2 | Level 3 |
|---|--------------------------------|---------|---------|
| › Option 1 | \$15 | \$30 | \$50 |
| › Option 2 | \$20 | \$40 | \$65 |
| Mail order (up to 90-day supply) | 2.5 times the retail copayment | | |

NOTE: If a nonparticipating pharmacy is used, the claim will be covered at 70 percent after applicable copayment.

RxImpact

| Retail (30-day supply) | Example | Prescription drug allowance |
|------------------------|--|-----------------------------|
| › Group A | asthma, infections, juvenile diabetes, contraceptives, antidepressants | \$30 allowance |
| › Group B | cancer, heart disease, multiple sclerosis | \$20 allowance |
| › Group C | antihistamines, anti-inflammatory, antacids | \$10 allowance |
| › Group D | cosmetic, obesity | \$0 allowance* |

Mail order (up to 90-day supply)—Up to three times applicable allowance amount

Copayment maximum—\$100 per monthly prescription and \$2,500 annual out-of-pocket maximum for drug groups A, B and C only

* Employees can purchase drugs at Humana's negotiated price which is below the average wholesale price.



Insured by Humana Insurance Company

This is not a complete disclosure of plan qualifications and limitations. Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. This guide is available at www.disclosure.humana.com or through your employer. Premiums and benefits vary based on the plan selected.