

# STATE OF ILLINOIS FY 2010 SUMMARY OF BENEFITS

## HUMANA BENEFIT PLAN OF ILLINOIS

|                              |                                |
|------------------------------|--------------------------------|
| Deductible                   | \$0                            |
| Lifetime Maximum Benefits    | Unlimited                      |
| Annual Out of Pocket Maximum | Single \$3,000, Family \$6,000 |

| SERVICES  | BENEFITS               |               | SPECIAL PROVISIONS  |
|---|------------------------|---------------|---|
|   | Member Copayment       | Then HMO Pays |   |
| <b>PREVENTIVE HEALTH SERVICES</b>                                     |                        |               |   |
| Routine Health Screenings   | \$15                   | 100%          |   |
| Well Child Care, Including Immunizations                              | \$15                   | 100%          |   |
| <b>PHYSICIAN SERVICES</b>   |                        |               |   |
| Primary Care Physician Office Visit                                   | \$15                   | 100%          |   |
| Specialist Office Visit   | \$20                   | 100%          |   |
| Allergy Testing and Care  | \$15                   | 100%          |   |
| Gynecological Care*   | \$15                   | 100%          |   |
| Maternity Care*   | \$100                  | 100%          | One Copayment Per Delivery  |
| Surgical Procedures   | \$0                    | 100%          |   |
| Inpatient Hospital Visits   | \$0                    | 100%          |   |
| X-ray and Laboratory Services   | \$0                    | 100%          |   |
| <b>INPATIENT HOSPITAL SERVICES</b>                                    |                        |               |   |
| All Inpatient Services  | \$275 Per Admission    | 100%          |   |
| <b>OUTPATIENT HOSPITAL SERVICES</b>                                   |                        |               |   |
| Outpatient Surgery  | \$175                  | 100%          | One Copayment Per Surgery   |
| Outpatient Diagnostic X-ray and Laboratory Services                   | \$0                    | 100%          |   |
| <b>OTHER COVERED SERVICES</b>   |                        |               |   |
| Emergency Care*   | Lesser of \$200 or 50% | 100%          | Non-emergency Not Covered: Copayment Waived if Admitted; Must Notify Humana Within 48 Hours |
| Ambulance Transportation  | \$0                    | 100%          | If Emergency Or Pre-authorized  |
| Organ Transplantation   | \$0                    | 100%          | Non-Experimental Transplants At a Humana Approved Facility                                  |
| Home Health   | \$20                   | 100%          | Up To 60 Visits Per Year  |
| Skilled Nursing Facility  | \$0                    | 100%          | Up To 45 Days Per Year  |
| Outpatient Rehabilitation (Physical, Occupational and Speech Therapy) | \$15                   | 100%          | Up To 60 Combined Outpatient Visits Per Year  |
| Hearing Aids  |                        | \$600         | \$600 Maximum Benefit Every 3 Years   |
| Hearing Exams   |                        | \$150         | \$150 Maximum Benefit Every 3 Years   |
| Durable Medical Equipment**   | 20%                    | 80%           | \$10,000 Maximum Benefit Per Year   |

\*Does Not Require Primary Care Physician Referral

\*\*Copayments, and/or Coinsurance Do Not Apply Towards the Annual Maximum Out-of-Pocket

All Medical Care Must Be Preauthorized, Arranged Or Provided By Your Primary Care Physician

This document is intended As a Summary Only. Please Refer to the Evidence of Coverage and Benefit Schedule for Further Details.

# HUMANA BENEFIT PLAN OF ILLINOIS

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| <b>SERVICES</b>  | <b>BENEFITS</b>     |               | <b>SPECIAL PROVISIONS</b>       |
|--|---------------------|---------------|---------------------------------|
|  | Member Copayment    | Then HMO Pays |                                 |
| <b>MENTAL HEALTH</b>   |                     |               |                                 |
| <i>Inpatient Services</i>  |                     |               |                                 |
| Serious Mental Health Conditions                                       | \$275 Per Admission | 100%          | <i>Up To 45 Days Per Year</i>   |
| Non-Serious Mental Health Conditions                                   | \$275 Per Admission | 100%          | <i>Up To 10 Days Per Year</i>   |
| <i>Outpatient Services</i>   |                     |               |                                 |
| Serious Mental Health Conditions                                       | \$20                | 100%          | <i>Up to 60 Visits Per Year</i> |
| Non-Serious Mental Health Conditions                                   | \$20                | 100%          | <i>Up to 20 Visits Per Year</i> |
| <i>Note: Serious Mental Health Conditions are defined by state law</i> |                     |               |                                 |
| <b>SUBSTANCE ABUSE</b>   |                     |               |                                 |
| Inpatient Services   | \$275 Per Admission | 100%          | <i>Up To 10 Days Per Year</i>   |
| Outpatient Services  | \$0                 | 100%          | <i>Up To 20 Visits Per Year</i> |

**EXCLUSIONS:**

Non-covered benefits include, but are not limited to: non-emergency services not preauthorized, arranged, or provided by your Primary Care Physician; investigational or experimental procedures; services not medically necessary; personal or convenience items; radial keratotomy; glasses or contact lenses; hearing examinations and hearing aids; custodial care; marital or employment physicals; cosmetic services or surgery; charges for missed appointments; reversal of sterilization; food supplements; medical or surgical treatment for reduction of weight; transexual surgery; over-the-counter drugs; dental services; foot or orthotics; abortions; and work related injury or illness.

*Please refer to the Evidence of Coverage (EOC) and Benefit Schedule for complete details on all limitations and exclusions.*

**IMPORTANT POINTS TO REMEMBER**

- You must select a Primary Care Physician for each family member at the time of enrollment. Each family member can have the same Primary Care Physician or each may select a different Primary Care Physician.
- College students or members on vacation or business travel are covered for emergency and urgent care outside the HMO service area.
- There is no annual deductible. For some services you will be required to pay a nominal copayment at the time service is received.
- In order to enroll in the HMO, you and your dependents must permanently reside within the HMO service area, or work within the HMO service area and reside in a contiguous county.
- All medical management is handled between Humana Benefit Plan of IL and the provider. Members are required to notify Humana Benefit Plan of IL within 48 hours of any emergency or urgent care.
- When the HMO is the secondary carrier, you must follow all the requirements of the HMO to receive secondary benefits.

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*All Medical Care Must Be Preauthorized, Arranged Or Provided By Primary Care Physician*

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You are encouraged to review the information in these marketing materials. THESE MARKETING MATERIALS ARE NOT LEGAL DOCUMENTS. For full benefit information please refer to your contract or certificate, or contact Humana Benefit Plan of IL. If any inconsistencies exist between these marketing materials and the applicable contract or certificate, the terms of the contract or certificate will control.