

## ICONMA

|  |   | Plan pays for services from<br><b>PARTICIPATING</b> providers  | Plan pays for services from<br><b>NONPARTICIPATING</b> providers  |
|--|---|--|---|
| <b>Office visit copayment</b>  |   | \$30 primary care/\$50 specialist  | Not applicable  |
| <b>Deductible</b>  | <ul style="list-style-type: none"> <li>individual</li> <li>family</li> </ul>  | \$2,000  | \$6,000   |
| <ul style="list-style-type: none"> <li>per calendar year</li> <li>copayments do not apply</li> </ul>                 |   | Two times the individual participating deductible  | Two times the individual nonparticipating deductible  |
| <b>Out-of-pocket maximum</b>   | <ul style="list-style-type: none"> <li>individual</li> <li>family</li> </ul>  | \$0  | \$6,000   |
| <ul style="list-style-type: none"> <li>per calendar year</li> <li>deductibles and copayments do not apply</li> </ul> |   | Two times the individual participating out-of-pocket max   | Two times the individual nonparticipating out-of-pocket max   |
| <b>Preventive care</b>   | <ul style="list-style-type: none"> <li>preventive office visits</li> <li>preventive lab and X-ray</li> <li>Pap smear and mammogram</li> <li>prostate screening</li> <li>child immunizations to age 18</li> <li>flu and pneumonia immunizations</li> <li>endoscopic services (including, but not limited to colonoscopy)</li> </ul>  | <ul style="list-style-type: none"> <li>100% after office visit copayment</li> <li>100%</li> <li>100% after deductible</li> </ul>   | <ul style="list-style-type: none"> <li>70% after deductible</li> <li>70% after deductible</li> <li>70% after deductible</li> </ul>  |
| <b>Physician services</b>  | <ul style="list-style-type: none"> <li>office visits</li> <li>diagnostic lab and X-ray</li> <li>allergy testing</li> <li>injections and serums (including allergy)</li> <li>inpatient and outpatient services</li> <li>surgery</li> <li>emergency room visits</li> </ul>  | <ul style="list-style-type: none"> <li>100% after office visit copayment</li> <li>100%</li> <li>100% after \$5 copayment per visit</li> <li>100% after deductible</li> <li>100%</li> </ul>   | <ul style="list-style-type: none"> <li>70% after deductible</li> <li>70% after deductible</li> <li>70% after deductible</li> <li>70% after deductible</li> <li>100%</li> </ul>  |
| <b>Facility services</b>   | <ul style="list-style-type: none"> <li>inpatient and outpatient services</li> <li>outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) –hospital, freestanding facility and clinic</li> <li>emergency services (copayment waived if admitted)</li> </ul>   | <ul style="list-style-type: none"> <li>100% after deductible</li> <li>100% after \$150 copayment</li> </ul>  | <ul style="list-style-type: none"> <li>70% after deductible</li> <li>100% after \$150 copayment</li> </ul>  |
| <b>Other medical services</b>  | <ul style="list-style-type: none"> <li>skilled nursing facility (up to 60 days per calendar year)</li> <li>hospice</li> <li>home health care (up to 100 visits per calendar year)</li> <li>physical, occupational, cognitive, speech and audiology therapy (combined limit up to 25 visits per calendar year)</li> <li>durable medical equipment (limited to \$2,500 of covered services per calendar year)</li> <li>urgent care</li> <li>spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year)</li> <li>ambulance</li> <li>maternity</li> <li>transplant services</li> </ul> | <ul style="list-style-type: none"> <li>100% after deductible</li> <li>100% after specialist copayment per visit</li> <li>100% after deductible</li> <li>Same as any other illness</li> <li>Same as any other illness when services are received from a Humana Transplant Network provider</li> </ul> | <ul style="list-style-type: none"> <li>70% after deductible</li> <li>70% after deductible</li> <li>100% after participating deductible</li> <li>Same as any other illness</li> <li>Same as any other illness. Covered expenses are limited to a maximum allowance of \$35,000 per transplant</li> </ul> |
| <b>Lifetime maximum benefit</b>  |   |  | \$5,000,000   |

## Michigan 100/70 Copay plan

|   |   | Plan pays for services from <b>PARTICIPATING</b> providers | Plan pays for services from <b>NONPARTICIPATING</b> providers |
|---|---|--|---|
| <b>Mental health, chemical and alcohol dependency</b> | • inpatient services (up to 10 days per calendar year)  | 100% after deductible                                      | 70% after deductible  |
|   | • mental health outpatient and office therapy sessions (up to 15 visits per calendar year)                    | 100% after specialist office visit copayment               | 70% after deductible  |
|   | • chemical and alcohol dependency outpatient and office therapy sessions (subject to US Consumer Price Index) |  |   |

## Network

### Cofinity/ChoiceCare Network

The Cofinity/ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, and it's growing daily. This PPO network gives employees coast-to-coast access to favorably priced health care. Plus, Humana maintains strong provider relationships with local PPO networks for added coverage.

## Pharmacy

Detailed drug lists are available at [Humana.com](http://Humana.com) for each pharmacy plan and level.

### Rx4

| Retail (30-day supply)                                   | Level 1                              | Level 2 | Level 3 | Level 4 |
|--|--------------------------------------|---------|---------|---------|
|  | \$10                                 | \$40    | \$65    | 25%     |
| <b>Mail order</b> (up to 90-day supply)                  | 2.5 times the retail copayment       |         |         |         |
| <b>Copayment maximum</b> (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.



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](http://www.disclosure.humana.com) or through your employer. Premiums and benefits vary based on the plan selected.

This rider modifies your coverage as follows:

- Covered expenses incurred to meet your deductible during the last three months of the year can be applied toward satisfaction of the following year's individual or family deductible
- Provisions of your plan regarding how deductibles accumulate with regard to expenses for participating versus nonparticipating providers still apply
- Requirements for meeting your plan's family and individual deductibles still apply
- Plan limitations and exclusions apply. Refer to your certificate for details.



Humana Plans are offered by the Family of Insurance and Health Plan Companies including Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plans of Michigan, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. – A Health Maintenance Organization or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009

For Arizona Residents: Offered by Humana Health Plan, Inc.  
or insured by Humana Insurance Company, Emphesys Insurance Company

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance)  
for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions