

Wisconsin 80/50 Copay plan

		Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers
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 	\$500/\$1,000/\$1,500/\$2,000 \$3,000/\$4,000/\$5,000	Three times the individual participating deductible
		\$1,000/\$2,000/\$3,000/\$4,000 \$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 	\$2,000/\$3,000/\$4,000	Three times the individual participating out-of-pocket max
		\$4,000/\$6,000/\$8,000	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) 	100% after office visit copayment 100% 80% after deductible	70% after deductible 70% after deductible 50% after deductible
Physician services	<ul style="list-style-type: none"> office visits diagnostic lab and X-ray allergy testing allergy injections and serums inpatient and outpatient services surgery emergency room visits 	100% after office visit copayment 100% 100% after \$5 copayment per visit 80% after deductible 100%	70% after deductible 70% after deductible 70% after deductible 50% after deductible 100%
Facility services	<ul style="list-style-type: none"> inpatient and outpatient services outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) —hospital, freestanding facility and clinic emergency services (copayment waived if admitted) 	80% after deductible 100% after \$150 copayment	50% after deductible 100% after \$150 copayment
Other medical services	<ul style="list-style-type: none"> skilled nursing facility (up to 60 days per confinement) hospice home health care (up to 100 visits any 12-month period) physical, occupational, cognitive, speech and audiology therapy (combined limit up to 25 visits per calendar year) urgent care facility spinal manipulations, adjustments and modalities durable medical equipment (limited to \$2,500 of covered services per calendar year) ambulance maternity transplant services 	80% after deductible 100% after specialist copayment per visit 80% after deductible 80% after deductible Same as any other illness Same as any other illness when services are received from a Humana Transplant Network provider	50% after deductible 70% after deductible 50% after participating deductible 80% after participating deductible 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, chemical and alcohol dependency	<ul style="list-style-type: none"> inpatient services (up to 10 days per calendar year) outpatient & office therapy sessions (up to 15 visits per calendar year) 	80% after deductible 100% after specialist office visit copayment	50% after deductible 70% after deductible

Wisconsin Humana National POS 80/50 Copay plan

Network

National POS—Open Access network

Humana National POS—Open Access network is one of our largest and is growing daily. The network combines the best of Humana's fee-for-service provider contracts, providing improved discounts while maintaining broad network provider scope.

Pharmacy options

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

Rx4

Retail (30-day supply)	Level 1	Level 2	Level 3	Level 4
› Option 1	\$10	\$35	\$55	25%
› Option 2	\$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.

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 prescription and \$2,500 annual out-of-pocket maximum for drugs groups A, B and C only	

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



Offered by Humana Wisconsin Health Organization Insurance Corporation
Insured by Humana Insurance Company

This is not a complete disclosure of plan qualifications and limitations. Your group may have specific limitations and exclusions not included on this list. Please check your Certificate of Coverage for this complete listing. The Certificate of Coverage is the document upon which benefit payment will be determined. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.