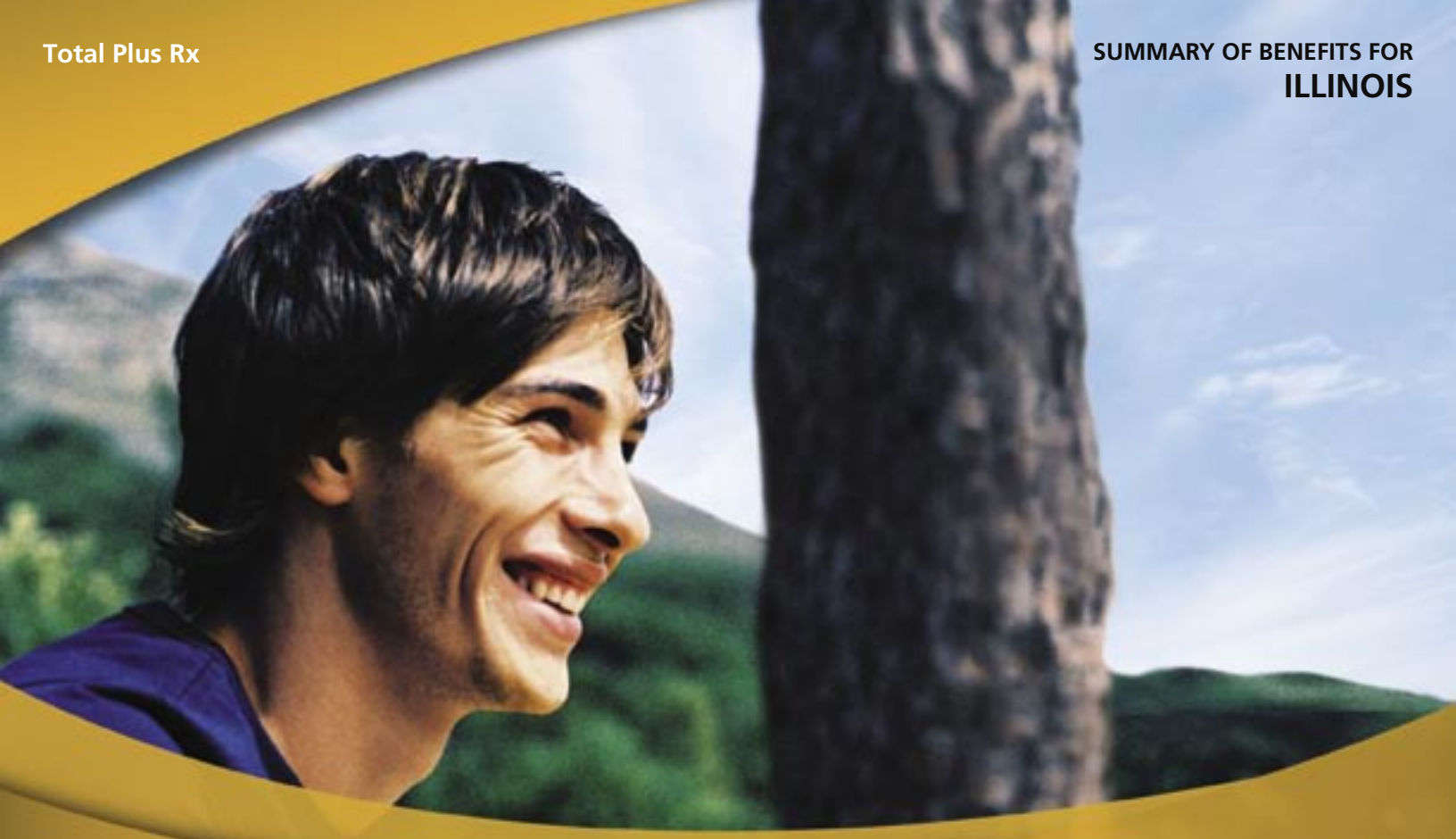
SUMMARY OF BENEFITS FOR
ILLINOIS



Total Plus Rx

- Low monthly cost
- $7,500/In-network Single Deductible
- $15,000/In-network Family Deductible
- Provides a safety net of coverage

monogram™
from HumanaOne

PERSONAL HEALTH PLAN

Humana One® the plans you shape.

Insured by Humana Insurance Company or HumanaDental Insurance Company

IL-46174-HH 6/07

You're the *one*
who's living in the moment.

HumanaOne® monogram™ personal health plan is just for you.

You're young, healthy, and unbeatable. You shouldn't have to think about health insurance policies, hospital stays and prescription drugs, right? Remember though, in life, things happen. And what if that "thing" happens to be an accident? How would you cover a five-figure hospital bill?

Your savings? Probably not. The lottery? Dream on. Get this: nearly half of all personal bankruptcies in the U.S. are due to medical expenses[1], and that's why people who think ahead buy health insurance like **monogram.**

monogram is an affordable health plan that gives you a safety net of coverage if you ever need it. Even cooler, this plan offers a preventive care benefit that covers some costs for annual exams and physicals.

You can shape this plan to your style so you won't spend too much for benefits you'll never use. So take a look, see what **monogram** has to offer. It's the smartest thing you'll do today — seriously.

[1] Source: Senate Bill 840, Senate Rules Committee, Senate Floor Analysis, 5/24/05.

‡ Daily costs are averaged based on rates published by providers of the goods and services listed above. Because prices may vary from day-to-day, the actual price you pay for the above items may not be the same as what is quoted above. The prices are only meant to help you compare prices to other everyday expenses and are not guaranteed prices.

*‡ Rates are based on in-network coverage for plans in Boca Raton, FL, 33401 with a $7,500 deductible. All rates quoted are for a 22-year-old male, non-tobacco user with a 4/1/07 effective date and are examples only. Actual rates vary by ZIP code, age, gender, number of members, health conditions and other variables. All cited plans, quoted rates and examples are subject to terms and limitations of the policy.

	Grande Soy Latte	Internet Service	Cell Phone	monogram from HumanaOne
Compare what you might pay for‡…	$3.25/day	$1.93/day	$1.99/day	**$1.00/day***‡

monogram is an ideal health plan if:

You want low-cost protection just in case an accident happens.

You're healthy and seldom visit doctors and hospitals but need some coverage for annual exams.

Your lifestyle situation requires it, like:

- Your employer doesn't offer a group health plan
- You're a recent college grad or a graduate student
- You're not eligible for group benefits because you only work part-time
- You're no longer covered on your spouse's or parents' health plan

Plan Snapshot*

	In-Network Coinsurance		In-Network Plan Deductible		Separate Prescription Deductible	Lifetime Maximum
	Health Plan Pays	You Pay	Single	Family		
monogram Total Plus Rx	**100%** (copays may apply)	**0%**	**$7,500**	**$15,000**	**$1,000 per individual** (copays apply)	**$2 million per individual**

* For a list of plan benefits, covered services and out-of-network coverage see page 8.

Shape Your Plan
With These Optional Benefits:

- **Dental Insurance**
- **$5 Million Lifetime Maximum**
- **Extra Accident Protection**

monogram™: it's a safety net… just in case.

Coverage that's there if you ever need it.

monogram is designed to protect you if you're ever in need of expensive medical treatment. Here are some of the plan's key benefits:

- **Deductibles to Fit Your Needs.** A deductible is the total dollar amount you pay annually before **monogram** begins to pay for covered expenses.†

Individual Deductible	Family Deductible*
$7,500 (in-network)	$15,000 (in-network)

- **100% Coverage for Most In-Network Medical Services.** Once you meet your annual deductible this plan pays 100 percent for most covered in-network medical costs.†
- **Prescription Drug Coverage. monogram** includes a prescription drug benefit with copayments as low as $15 for common prescriptions. Certain drug levels require meeting a separate prescription deductible.
- **$2 Million Worth of Lifetime Coverage.** Amount is per covered person.
- **Your Plan Goes Where You Go.** Whether you're traveling by plane, train or automobile, your health plan goes with you. Because of our large network, you'll more than likely be able to access in-network services across the continental United States.

Shape your plan with additional benefits:

- **Get EXTRA Accident Protection (Supplemental Accident Benefit).** What if you had a minor accident that doesn't cost a lot? It's still a long way to go before meeting your deductible. With EXTRA Accident Protection you're covered right away — up to either $500 or $1,000 per accidental injury.
- **Keep Your Smile Looking Healthy.** Dental insurance benefits are available, including teeth whitening services.
- **Increase Your Lifetime Maximum.** Increase your coverage to $5 million to get the added protection you need.

Examples of potential medical care costs and savings

Procedure	Typical Cost (no insurance)	You Only Pay (with **monogram**)	You Save
Spinal Fracture‡– includes: ambulance, ER, surgery, ICU, hospital stay, halo, physical therapy, occupational therapy	**$200,000**	**Member pays $7,500**	**$192,500**
Compound Leg Fracture‡ – includes: ambulance, ER, surgery, hospital stay, physical therapy	**$75,000**	**Member pays $7,500**	**$67,500**

* Two family members must meet their individual deductible.

† For out-of-network benefits and details, see pages 8 and 9.

‡ The cost listed for the procedure is based on actual claims and is not limited to severity of injury, member's age, state and ZIP code of residence, and other health conditions. Can vary on provider's billing services. Example does not include copays and is based on an in-network deductible of $7,500 where member has yet to pay any out-of-pocket costs toward their deductible. Terms and limitations of policy apply.

monogram™ is a plan you can count on.

You're not paying for frills, just protection.

You'll find that **monogram** fits your budget because it provides a high deductible with a lower premium. In fact, it could cost up to 73 percent less than what you might pay for another major medical plan.*

Plus, you get an initial 12-month rate guarantee as long as you stay within the same plan and live in the same ZIP code.

* monogram from Humana*One* is a low-cost plan in comparison to our Humana*One* Portrait plan.

We've nailed down all the details.

Look for Free.

If you're not completely satisfied for any reason, either call and cancel or return the policy to us within 10 days of receiving it for a full refund on your premium.

No Runaround. No Hassle.

You'll probably never need to call us — but if you do, we'll see to it that you get the right information ASAP. Our customer care consultants have your back.

You're Not Trapped.

There's no annual contract with **monogram**, so you can cancel your policy any time you wish.

Don't Worry … We've Got You Covered.

If you move anywhere in the continental United States — no problem. Your monogram plan benefits are portable, although your rate may change based on your new area, you won't have to reapply for coverage and risk being denied.

It's Easy to Apply for monogram.

You can apply for **monogram** through one convenient application online or over the phone — either way, there's not a bunch of paperwork for you. All applications are subject to approval.

Humana*One* ILLINOIS

MONOGRAM Total Plus Rx

	Plan pays for services at ***PARTICIPATING*** providers		Plan pays for services at ***NONPARTICIPATING*** providers	
Annual Deductible (1), (2)	**Single Deductible**	**Family Deductible** (3)	**Single Deductible**	**Family Deductible** (3)
• Annual amount *(does not apply to maximum out-of-pocket expense)*	$ 7,500	$ 15,000	$15,000	$ 30,000
• Deductible Carryover	Covered expenses incurred in the last three months of the calendar year and applied to the deductible will be credited to the next calendar year deductible.			
Maximum Out-of-Pocket Expense Limit (1), (2)				
• Individual	$0		$5,000	
• Family	$0		$10,000	
Lifetime Maximum Benefit	$2,000,000 per covered person			
Preventive Care				
• Routine annual physical exam (4), (5) • Routine immunizations *(to age 18)* (4), (5) • Routine Pap smears and PSA (4), (5), (6) • Routine Mammograms (6) • Colorectal cancer screening, related exams and lab tests (6)	**100%**		**50%** after deductible	
• Routine lab, pathology and X-ray (4), (5)	**100%** after deductible		**50%** after deductible	
Physician Services				
• Office visits *(includes diagnostic lab and X-ray)* • Allergy testing, injections and serum • Inpatient services • Outpatient services *(includes surgery)* (7)	**100%** after deductible		**75%** after deductible	
Hospital Services				
• Inpatient care • Outpatient surgery – facility (7) • Outpatient nonsurgical	**100%** after deductible		**75%** after deductible	
• Emergency room *(including physician visits)*	**100%** after $125 copayment per visit and deductible *(copayment waived if admitted)*		**75%** after $125 copayment per visit and deductible *(copayment waived if admitted)*	
Prescription Drugs (8)				
• Prescription drug deductible *(Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts.)* (2)	$1,000 prescription drug deductible per individual		$1,000 prescription drug deductible per individual	
• Benefit for each prescription or refill *(up to 30-day supply)*	**100%** after:		**70%** after:	
– Level One - lowest copayment for lowest cost generic and brand-name drugs	$15 copayment is not subject to prescription drug deductible		$15 copayment is not subject to prescription drug deductible	
– Level Two - higher copayment for higher cost generic and brand-name drugs	$40 copayment after prescription drug deductible		$40 copayment after prescription drug deductible	
– Level Three - higher copayment than Level Two for higher cost, mostly brand-name drugs that may have generic or therapeutic equivalents in Levels One or Two	$65 copayment after prescription drug deductible		$65 copayment after prescription drug deductible	
– Level Four - highest copayment for high-technology drugs *(certain brand-name drugs, biotechnology drugs and self-administered injectable medications)*	**25%** copayment after prescription deductible up to $2,500 maximum out-of-pocket per calendar year		**25%** copayment after prescription deductible up to $2,500 maximum out-of-pocket per calendar year	
• Mail order *(90-day supply)*	**100%** after three times the retail copayment		**70%** after three times the retail copayment	

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Other Medical Services		
• Skilled nursing facility *(up to 30 days per calendar year)* (9) • Home healthcare *(up to 60 visits per calendar year)* (9) • Durable medical equipment (9) • Hospice (9), (10) • Complications of pregnancy and sick baby services	**100%** after deductible	**75%** after deductible
• Transplant services *(organ)* (9)	**100%** after deductible *(when services are performed at a National Transplant Network provider)*	**75%** after deductible *(limited to $35,000 per covered transplant)*
Mental Health *(includes mental disorders, alcohol and chemical dependence)* (4)		
• Inpatient and Outpatient care *(Combined $2,500 per calendar year maximum. Outpatient care not to exceed $500 of the $2,500 calendar year maximum.)*	**50%** after deductible	**50%** after deductible
Optional Benefits (11)		
• Lifetime maximum benefit	$5,000,000 per covered person	
• $500 Supplemental Accident Benefit *(Treatment must be provided within 90 days of the injury.)*	First $500 per accident at **100%**, then base plan benefits apply	
• $1,000 Supplemental Accident Benefit *(Treatment must be provided within 90 days of the injury.)*	First $1,000 per accident at **100%**, then base plan benefits apply	

Optional Dental benefits *(with teeth whitening)* (12)

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of the more than 75,000 dentist locations in the PPO network. You can find a dentist by visiting **Humana.com**.

Preventive services plan pays **100%** no deductible
- Oral examinations
- Routine cleanings
- X-rays
- Sealants
- Topical fluoride treatment

Basic services plan pays **50%** after deductible
- Emergency exams and palliative care for pain relief
- Thumb sucking and harmful habit appliances
- Space maintainers
- Amalgam, composite fillings
- Oral surgery
- Extractions (routine)
- Non-cast stainless steel crowns
- Partial or complete denture repairs/adjustments

Teeth whitening services plan pays **50%** after deductible
- $200 lifetime maximum

Major services plan pays **50%** after deductible
- Endodontics (root canals)
- Periodontics
- Crowns
- Inlays and onlays
- Partial or complete dentures
- Denture relines/rebases
- Removable or fixed bridgework

Orthodontia discount
Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.

Annual Deductible
- **$50** individual
- **$150** family

Annual maximum benefit
- **$1,000**

To be covered, expenses must be medically necessary and specified as covered. Please see your policy for more information on medical necessity and other specific plan benefits.

(1) When you obtain care from nonparticipating providers:
   – 50 percent of your payment toward the deductible is credited to the deductible for participating providers.
   – 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for participating providers.

   Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.

(2) Copayments do not apply to the deductible or out-of-pocket maximum. The medical out-of-pocket maximum does not apply to prescription drugs or mental health services.

(3) Two family members must meet their individual deductible.

(4) Benefit payable after 90-day waiting period for preventive care and 12 month waiting period for mental health.

(5) $300 of covered expenses per person per calendar year, subject to applicable coinsurance.

(6) Age and/or frequency limits apply.

(7) Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not include strangulated or incarcerated hernia).

(8) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.

(9) Prior authorization required in order to be eligible for maximum benefits.

(10) Counseling for the hospice patient and immediate family is limited to 15 visits per family per lifetime. Medical Social Services limited to $100 per family per lifetime.

(11) These benefits are optional and can be added to your plan for an additional cost. Optional benefits may not be available in all areas.

(12) This is not a complete disclosure of plan qualifications and limitations. Waiting periods apply: six months on basic services and teeth whitening, 12 months on major services. Please review the specific Dental Limitations & Exclusions before applying for coverage.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your policy.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee.

You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Participating primary care and specialist physicians and other providers in Humana's networks are <u>not</u> the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Medical Limitations and Exclusions

This is an outline of the limitations and exclusions for the Humana*One* Individual Health Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

PRE-EXISTING CONDITIONS

A pre-existing condition is a sickness or bodily injury which was treated within the 24-month period prior to the covered person's effective date of coverage or which produced symptoms that would cause an ordinarily prudent person to seek medical diagnosis or treatment within the 12-month period prior to the covered person's effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

OTHER EXPENSES NOT COVERED

Unless stated otherwise no benefits are payable for expenses arising from:

1. Services not medically necessary or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
3. Services while confined in a hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the covered person's home or who is a family member, or that are performed in association with a service that is not covered under the policy.
4. Charges in excess of the maximum allowable fee or which exceed any policy benefit maximum.
5. Expenses incurred before the effective date or after the date coverage terminated.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Any drug, medicine or device which is not FDA approved.
9. Medications, drugs or hormones to stimulate growth.
10. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
11. Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature; experimental or investigational use drugs.
12. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
13. Drugs used in treatment of nail fungus.
14. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
15. Vitamins, dietary products and any other nonprescription supplements.
16. Infertility services.
17. Pregnancy and well-baby expenses.
18. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
19. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
20. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
21. Services received in an emergency room unless required because of emergency care.
22. Dental services (except for dental injury), appliances or supplies.
23. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
24. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
25. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures, unless qualified as morbid obesity.
26. Nicotine habit or addiction; educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
27. Foot care services.
28. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
29. Health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
30. Hair prosthesis, hair transplants or implants and wigs.
31. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
32. Injury or sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a covered person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the covered person is not covered under a Workers' Compensation plan, except for certain professions or activities as stated in the policy.
33. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a mental disorder.
34. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
35. Charges covered by other medical payments insurance.
36. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
37. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.

Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the Humana*One* Individual Dental Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

Unless stated otherwise, no benefits are payable for expenses arising from:

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government, unless legally required to pay.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.

Notes

Notes

Notes

Your questions answered about monogram™.

Q. How does monogram differ from higher-priced health insurance?

A. Many higher-priced insurance plans are designed for people who want to be covered for future medical care. **monogram** is more affordable because of the higher deductible. It provides a safety net of coverage if you ever need it.

Q. Can I afford the cost of monogram?

A. Your daily cost for **monogram** may be comparable to what you might spend on your cell phone, lattes and other expenses you probably seldom think about (Check it out on page 3).

Policy Number:
GN-70129 et al
IL-70141-HD et al

IL-46174-HH

HUMANA®
Guidance when you need it most