

Illinois 100/70 Copay plan

		Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers
Office visit and urgent care copay options		<ul style="list-style-type: none"> • \$25 primary care/\$55 specialist/\$75 urgent care • \$35 primary care/\$75 specialist/\$100 urgent care 	Not applicable
Deductible options	Individual	\$1,000/\$1,500/\$2,000/\$2,500/ \$3,000/\$5,000	\$3,000/\$4,500/\$6,000/\$7,500/ \$9,000/\$15,000
<ul style="list-style-type: none"> • per calendar year • copays do not apply 	Family	\$2000/\$3,000/\$4,000/\$5,000/ \$6,000/\$10,000	\$6,000/\$9,000/\$12,000/\$15,000/ \$18,000/\$30,000
Out-of-pocket maximum	Individual	Not applicable	\$9,000
<ul style="list-style-type: none"> • per calendar year • deductibles and copays do not apply 	Family	Not applicable	\$27,000
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%	70% after deductible
Physician services			
<ul style="list-style-type: none"> • office visits • diagnostic lab and X-ray (performed in office and billed by physician) • allergy testing • injections (including allergy) • inpatient services • outpatient services • surgery • emergency room visits 		100% after office visit copay 100% 100% after \$5 copay 100% after deductible 100%	70% after deductible 70% after deductible 70% after deductible 70% after deductible 100%
Facility services			
<ul style="list-style-type: none"> • inpatient services • outpatient services • outpatient diagnostic lab and X-ray • outpatient surgery • emergency services (copay waived if admitted) 		100% after deductible 100% after \$250 copay	70% after deductible 100% after \$250 copay
Other medical services			
<ul style="list-style-type: none"> • retail clinic • urgent care • spinal manipulations, adjustments, and modalities (combined limit to 20 visits per calendar year) • physical, occupational, cognitive, speech and audiology therapy (combined limit to 80 visits per calendar year) • advanced imaging (PET, MRI, MRA, CAT, SPECT) • hospice • home health care (limited to 100 visits per calendar year) • skilled nursing facility (limited to 60 days per calendar year) • ambulance • maternity • transplant services 		100% after primary care copay 100% after urgent care copay 100% after specialist copay 100% after deductible 100% after deductible Same as any other illness Same as any other illness when services are received from a Humana Transplant Network provider	70% after deductible 70% after deductible 70% after deductible 70% after deductible 100% after participating deductible Same as any other illness Same as any other illness. Benefits payable will not exceed the non-network benefit limit of \$35,000 per covered organ transplant
Mental health and chemical dependency¹			
<ul style="list-style-type: none"> • inpatient services (combined mental health and chemical dependency limit to 10 days per calendar year) • outpatient and office therapy sessions (combined mental health, chemical and alcohol dependency limit to 15 visits per calendar year) 		100% after deductible 100% after specialist copay	70% after deductible 70% after deductible
Alcohol dependency			
<ul style="list-style-type: none"> • inpatient services 		Same as any other illness	Same as any other illness

¹ For groups with 51 or more employees, no limits apply to inpatient and outpatient services; benefit is covered the same as any other illness.

Illinois HumanaPPO 10 Copay 100/70 plan

Network

Humana/ChoiceCare Network® (CHC)

Humana's ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, and it's growing daily. As of February 1, 2010, our ChoiceCare Network includes 583,000 providers and 3,900 hospitals across all 50 states. 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 options

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

Rx4: Prescription drugs are assigned to one of four levels with corresponding copayment amounts or a discount.

Retail (30-day supply)	Level 1	Level 2	Level 3	Level 4*	Mail order (up to 90-day supply)
	\$10	\$45	\$70	25%	2.5 times the retail copayment

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

* Copayment maximum (applies to level 4 drugs only): \$2,500 per member per calendar year

Rx3: Prescription drugs are assigned to one of three levels with corresponding copayment amounts.

Retail (30-day supply)	Level 1	Level 2	Level 3	Mail order (up to 90-day supply)
	\$10	\$40	\$60	2.5 times the retail copayment

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



Insured by Humana Insurance Company

This plan imposes a pre-existing condition exclusion. 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 sales representative. Premiums and benefits vary based on the plan selected.