

## Illinois 70/50 Copay plan

		Plan pays for services from <b>PARTICIPATING</b> providers	Plan pays for services from <b>NONPARTICIPATING</b> providers
<b>Office visit copay options</b>		<ul style="list-style-type: none"> <li>\$20 primary care/\$40 specialist</li> <li>\$30 primary care/\$50 specialist</li> </ul>	Not applicable
<b>Deductible options</b>	<b>Individual</b>	\$250/\$500/\$1,000/\$1,500/\$2,000/ \$2,500/\$3,000/\$4,000/\$5,000	\$750/\$1,500/\$3,000/\$4,500/\$6,000/ \$7,500/\$9,000/\$12,000/\$15,000
<ul style="list-style-type: none"> <li>per calendar year</li> <li>copays do not apply</li> </ul>	<b>Family</b>	\$500/\$1,000/\$2,000/\$3,000/\$4,000/ \$5,000/\$6,000/\$8,000/\$10,000	\$1,500/\$3,000/\$6,000/\$9,000/\$12,000/ \$15,000/\$18,000/\$24,000/\$30,000
<b>Out-of-pocket maximum options</b>	<b>Individual</b>	\$3,000/\$4,000/\$5,000	\$9,000/\$12,000/\$15,000
<ul style="list-style-type: none"> <li>per calendar year</li> <li>deductibles and copays do not apply</li> </ul>	<b>Family</b>	\$6,000/\$8,000/\$10,000	\$18,000/\$24,000/\$30,000
<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> </ul>		100% after office visit copay	50% after deductible
		100%	50% after deductible
<ul style="list-style-type: none"> <li>endoscopic services (including, but not limited to colonoscopy)</li> </ul>		70% after deductible	50% after deductible
<b>Physician services</b>			
<ul style="list-style-type: none"> <li>office visits</li> </ul>		100% after office visit copay	50% after deductible
<ul style="list-style-type: none"> <li>diagnostic lab and X-ray</li> <li>allergy testing</li> </ul>		100%	50% after deductible
<ul style="list-style-type: none"> <li>injections (including allergy)</li> </ul>		100% after \$5 copay	50% after deductible
<ul style="list-style-type: none"> <li>inpatient services</li> <li>outpatient services</li> <li>surgery</li> </ul>		70% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>emergency room visits</li> </ul>		100%	100%
<b>Facility services</b>			
<ul style="list-style-type: none"> <li>inpatient services</li> <li>outpatient services</li> <li>outpatient diagnostic lab and X-ray</li> <li>outpatient surgery</li> </ul>		70% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>emergency services (copay waived if admitted)</li> </ul>		100% after \$150 copay	100% after \$150 copay
<b>Other medical services</b>			
<ul style="list-style-type: none"> <li>advanced imaging (PET, MRI, MRA, CAT, SPECT)</li> <li>hospice</li> <li>home health care (limited to 100 visits per calendar year)</li> <li>physical, occupational, cognitive, speech and audiology therapy (combined limit to 80 visits per calendar year)</li> <li>skilled nursing facility (limited to 60 days per calendar year)</li> </ul>		70% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>durable medical equipment (limited to \$2,500 of covered services per calendar year)</li> </ul>		70% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>urgent care</li> <li>spinal manipulations, adjustments and modalities (combined limit to 20 visits per calendar year)</li> </ul>		100% after specialist copay	50% after deductible
<ul style="list-style-type: none"> <li>ambulance</li> </ul>		70% after deductible	70% after participating deductible
<ul style="list-style-type: none"> <li>maternity</li> </ul>		Same as any other illness	Same as any other illness
<ul style="list-style-type: none"> <li>transplant services</li> </ul>		Same as any other illness when services are received from a Humana Transplant Network provider	Same as any other illness. Benefits payable will not exceed the non-network benefit limit of \$35,000 per covered organ transplant
<b>Lifetime maximum benefit</b>			\$5,000,000
<b>Mental health and chemical dependency<sup>1</sup></b>			
<ul style="list-style-type: none"> <li>inpatient services (combined mental health and chemical dependency limit to 10 days per calendar year)</li> </ul>		70% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>outpatient and office therapy sessions (combined mental health, chemical and alcohol dependency limit to 15 visits per calendar year)</li> </ul>		100% after specialist copay	50% after deductible
<b>Alcohol dependency</b>			
<ul style="list-style-type: none"> <li>inpatient services</li> </ul>		Same as any other illness	Same as any other illness

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

## 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, 2009, our ChoiceCare Network includes 544,000 providers and 4,000 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.

NOTE: Other network options may be available in your county. Call your Humana sales representative for more information.

## Pharmacy options

Detailed drug lists are available at [Humana.com](http://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)
› Option 1	\$10	\$30	\$50	25%	2.5 times the retail copayment
› Option 2	\$10	\$35	\$55	25%	
› Option 3	\$10	\$40	\$65	25%	

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)
› Option 1	\$15	\$30	\$50	2.5 times the retail copayment
› Option 2	\$20	\$40	\$65	

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

**RxImpact:** RxImpact groups drugs according to their ability to prevent a serious medical episode.

Humana pays an allowance for each group of drugs. The employee pays the remaining balance, if any.

Retail (30-day supply)	Example	Prescription drug allowance	Mail order (up to 90-day supply)
› Group A*	asthma, infections, juvenile diabetes, contraceptives, antidepressants	\$30 allowance	Up to 3 times applicable allowance amount
› Group B*	cancer, heart disease, multiple sclerosis	\$20 allowance	
› Group C*	antihistamines, anti-inflammatory, antacids	\$10 allowance	
› Group D	cosmetic, obesity	\$0 allowance**	

\* Copayment maximum: \$100 per monthly prescription and \$2,500 annual out-of-pocket maximum for drug groups A, B, and C only

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



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