Humana ChoicePOS 08 Copay Value

HUMANA
Guidance when you need it most

Illinois 100/70 plan

		Plan pays for services from **PARTICIPATING** providers	Plan pays for services from **NONPARTICIPATING** providers
Office visit copay options		• $25 primary care/$50 specialist • $35 primary care/$50 specialist	Not applicable
Deductible options • per calendar year • copays do not apply	**Individual**	$1,500/$2,000/$3,000/ $4,000/$5,000	$4,500/$6,000/$9,000/ $12,000/$15,000
	Family	$4,500/$6,000/$9,000/ $12,000/$15,000	$13,500/$18,000/$27,000/ $36,000/$45,000
Out-of-pocket maximum options • per calendar year • deductibles and copays do not apply	**Individual**	Not applicable	$6,000/$9,000/$12,000
	Family	Not applicable	$12,000/$18,000/$24,000
Preventive care			
• preventive office visits		100% after office visit copay	70% after deductible
• preventive lab and X-ray • Pap smear and mammogram • prostate screening • child immunizations to age 18 • flu and pneumonia immunizations		100%	70% after deductible
• endoscopic services (including, but not limited to colonoscopy)		100% after deductible	70% after deductible
Physician services			
• office visits		100% after office visit copay	70% after deductible
• diagnostic lab and X-ray • allergy testing		100%	70% after deductible
• injections (including allergy)		100% after $5 copay	70% after deductible
• inpatient services • outpatient services • surgery		100% after deductible	70% after deductible
• emergency room visits		100%	100%
Facility services			
• inpatient services • outpatient services • outpatient diagnostic lab and X-ray • outpatient surgery		100% after deductible	70% after deductible
• emergency services (copay waived if admitted)		100% after $150 copay	100% after $150 copay
Other medical services			
• advanced imaging (PET, MRI, MRA, CAT, SPECT)—hospital		100% after $400 copay	70% after deductible
• hospice • home health care (limited to 60 visits per calendar year) • physical, occupational, cognitive, speech and audiology therapy (combined limit to 40 visits per calendar year) • skilled nursing facility (limited to 60 days per calendar year)		100% after deductible	70% after deductible
• durable medical equipment (limited to $2,000 of covered services per calendar year)		100% after deductible	50% after participating deductible
• urgent care		100% after $75 copay	70% after deductible
• spinal manipulations, adjustments and modalities (combined limit up to 10 visits per calendar year)		100% after specialist copay	70% after deductible
• ambulance		100% after deductible	100% after participating deductible
• maternity		Same as any other illness	Same as any other illness
• transplant services		Same as any other illness when services are received rom 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
Lifetime maximum benefit		$5,000,000	
Mental health and chemical dependency[1]			
• inpatient services (combined mental health and chemical dependency limit to 10 days per calendar year)		100% after deductible	70% after deductible
• outpatient and office therapy sessions (combined mental health, chemical and alcohol dependency limit to 15 visits per calendar year)		100% after specialist copay	70% after deductible

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	Plan pays for services from **PARTICIPATING** providers	Plan pays for services from **NONPARTICIPATING** providers
Alcohol dependency		
• 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.

Network

Humana ChoicePOS Network

Humana's ChoicePOS Network is a local network of physicians and hospitals in the Chicago metropolitan area, and also includes access to Humana's ChoiceCare® Network. The ChoiceCare Network is one of the nation's largest, most cost-effective physician and hospital networks with more than 544,000 providers and 4,000 hospitals – and it's growing daily. This network gives employees coast-to-coast access to favorably priced healthcare.

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** 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%	

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.

Retail (30-day supply)	**Level 1**	**Level 2**	**Level 3**	**Mail order** (up to 90-day supply)
	$15	$30	$50	2.5 times the retail copayment

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.

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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.

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