

# Humana ChoicePOS 08 Copay Value

## Illinois 90/60 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>\$25 primary care/\$50 specialist</li> <li>\$35 primary care/\$50 specialist</li> </ul>	Not applicable
<b>Deductible options</b>	<b>Individual</b>	\$1,000/\$1,500/\$2,000/ \$3,000/\$4,000/\$5,000	\$3,000/\$4,500/\$6,000/ \$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>	\$3,000/\$4,500/\$6,000/ \$9,000/\$12,000/\$15,000	\$9,000/\$13,500/\$18,000/ \$27,000/\$36,000/\$45,000
<b>Out-of-pocket maximum options</b>	<b>Individual</b>	\$2,000/\$3,000/\$4,000	\$6,000/\$9,000/\$12,000
<ul style="list-style-type: none"> <li>per calendar year</li> <li>deductibles and copays do not apply</li> </ul>	<b>Family</b>	\$4,000/\$6,000/\$8,000	\$12,000/\$18,000/\$24,000
<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	60% after deductible
		100%	60% after deductible
<ul style="list-style-type: none"> <li>endoscopic services (including, but not limited to colonoscopy)</li> </ul>		90% after deductible	60% after deductible
<b>Physician services</b>			
<ul style="list-style-type: none"> <li>office visits</li> </ul>		100% after office visit copay	60% after deductible
<ul style="list-style-type: none"> <li>diagnostic lab and X-ray</li> <li>allergy testing</li> </ul>		100%	60% after deductible
<ul style="list-style-type: none"> <li>injections (including allergy)</li> </ul>		100% after \$5 copay	60% after deductible
<ul style="list-style-type: none"> <li>inpatient services</li> <li>outpatient services</li> <li>surgery</li> </ul>		90% after deductible	60% after deductible
<ul style="list-style-type: none"> <li>emergency room visits</li> </ul>		90%	90%
<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>		90% after deductible	60% after deductible
<ul style="list-style-type: none"> <li>emergency services (copay waived if admitted)</li> </ul>		90% after \$150 copay	90% after \$150 copay
<b>Other medical services</b>			
<ul style="list-style-type: none"> <li>advanced imaging (PET, MRI, MRA, CAT, SPECT)—hospital</li> </ul>		90% after \$400 copay	60% after deductible
<ul style="list-style-type: none"> <li>hospice</li> </ul>		90% after deductible	60% after deductible
<ul style="list-style-type: none"> <li>home health care (limited to 60 visits per calendar year)</li> <li>physical, occupational, cognitive, speech and audiology therapy (combined limit to 40 visits per calendar year)</li> <li>skilled nursing facility (limited to 60 days per calendar year)</li> </ul>			
<ul style="list-style-type: none"> <li>durable medical equipment (limited to \$2,000 of covered services per calendar year)</li> </ul>		50% after deductible	50% after participating deductible
<ul style="list-style-type: none"> <li>urgent care</li> </ul>		100% after \$75 copay	60% after deductible
<ul style="list-style-type: none"> <li>spinal manipulations, adjustments and modalities (combined limit up to 10 visits per calendar year)</li> </ul>		100% after specialist copay	60% after deductible
<ul style="list-style-type: none"> <li>ambulance</li> </ul>		90% after deductible	90% 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>		90% after deductible	60% 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	60% after deductible

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<b>Alcohol dependency</b>		
• inpatient services	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 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<sup>®</sup> 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](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%	

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