

## Illinois 90/60 Copay plan

		Plan pays for services from <b>PARTICIPATING</b> providers	Plan pays for services from <b>NONPARTICIPATING</b> providers
<b>Office visit copayment 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>	<ul style="list-style-type: none"> <li>individual</li> </ul>	\$250/\$500/\$1,000/\$1,500/\$2,000 \$2,500/\$3,000/\$4,000/\$5,000	Three times the individual participating deductible
	<ul style="list-style-type: none"> <li>family</li> </ul>	\$500/\$1,000/\$2,000/\$3,000/\$4,000 \$5,000/\$6,000/\$8,000/\$10,000	Three times the family participating deductible
<b>Out-of-pocket maximum options</b>	<ul style="list-style-type: none"> <li>individual</li> </ul>	\$1,000/\$2,000/\$3,000	Three times the individual participating out-of-pocket maximum
	<ul style="list-style-type: none"> <li>family</li> </ul>	\$2,000/\$4,000/\$6,000	Three times the family participating out-of-pocket maximum
<b>Preventive care</b>	<ul style="list-style-type: none"> <li>preventive office visits</li> </ul>	100% after office visit copayment	60% after deductible
	<ul style="list-style-type: none"> <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%	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 copayment	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 and serums including allergy</li> </ul>	100% after \$5 copayment per visit	60% after deductible
	<ul style="list-style-type: none"> <li>inpatient and 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>	100%	100%
<b>Facility services</b>	<ul style="list-style-type: none"> <li>inpatient and outpatient services</li> <li>outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)—hospital, freestanding facility and clinic</li> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>emergency services (copayment waived if admitted)</li> </ul>	100% after \$150 copayment	100% after \$150 copayment
<b>Other medical services</b>	<ul style="list-style-type: none"> <li>skilled nursing facility (up to 60 days per calendar year)</li> <li>hospice</li> <li>home health care (up to 100 visits per calendar year)</li> <li>physical, occupational, cognitive, speech and audiology therapy (combined limit up to 80 visits per calendar year)</li> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>urgent care</li> <li>spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year)</li> </ul>	100% after specialist copayment per visit	60% after deductible
	<ul style="list-style-type: none"> <li>durable medical equipment (limited to \$2,500 of covered services per calendar year)</li> </ul>	90% after deductible	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. Covered expenses are limited to a maximum benefit of \$35,000 per transplant
<b>Lifetime maximum benefit</b>			\$5,000,000

# Illinois

## HumanaPPO 08 90/60 Copay plan

Plan pays for services from **PARTICIPATING** providers

Plan pays for services from **NONPARTICIPATING** providers

<b>Mental health and chemical dependency</b>	• inpatient services (combined limit up to 10 days per calendar year)	90% after deductible	60% after deductible
	• outpatient & office therapy sessions (combined limit up to 15 visits per calendar year)	100% after specialist office visit copayment	60% after deductible
<b>Alcohol dependency services</b>	• inpatient services	Same as any other illness	Same as any other illness
	• outpatient and office therapy sessions (combined limit up to 15 visits per calendar year)	Same as any other illness	Same as any other illness

## Network options

### ChoiceCare Network®

Humana's ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, including 455,000 providers and 3,750 hospitals across all 50 states.

### Humana Preferred network (HPN)

Humana Preferred is an economical network plan option with providers from our national ChoiceCare Network. Providers were selected based on cost-efficiency measurements and other industry standards.

## Pharmacy options

Detailed drug lists are available at [www.humana.com](http://www.humana.com) for each pharmacy plan and level.

### Rx4

Retail (30-day supply)	Level 1	Level 2	Level 3	Level 4
› Option 1	\$10	\$30	\$50	25%
› Option 2	\$10	\$35	\$55	25%
› Option 3	\$10	\$40	\$65	25%
<b>Mail order</b> (up to 90-day supply)	2.5 times the retail copayment			
<b>Copayment maximum</b> (applies to Level 4 drugs only)	\$2,500 per member per calendar year			

NOTE: If a nonparticipating pharmacy is used, the claim will be covered at 75 percent after applicable copayment.

### Rx3

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

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

### RxImpact

Retail (30-day supply)	Example	Prescription drug allowance
› Group A	asthma, infections, juvenile diabetes, contraceptives, antidepressants	\$30 allowance
› Group B	cancer, heart disease, multiple sclerosis	\$20 allowance
› Group C	antihistamines, anti-inflammatory, antacids	\$10 allowance
› Group D	cosmetic, obesity	\$0 allowance*
<b>Mail order</b> (up to 90-day supply)—Up to three times applicable allowance amount		
<b>Copayment maximum</b> —\$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 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 employer. Premiums and benefits vary based on the plan selected.