

Illinois 100/70 Plan

		Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	
Up-front benefit allowance	Member benefit applies to medical services received from participating providers only. Does not apply to member copayments, preventive care or pharmacy benefits.	\$500 per calendar year per member	Not applicable	
Office visit copayment options		<ul style="list-style-type: none"> • \$20 primary care/\$40 specialist • \$30 primary care/\$50 specialist 	Not applicable	
Deductible options	<ul style="list-style-type: none"> • individual • family 	<ul style="list-style-type: none"> • per calendar year • copayments do not apply 	<ul style="list-style-type: none"> • \$1,000/\$1,500/\$2,000/\$2,500 • \$3,000/\$4,000/\$5,000 	<ul style="list-style-type: none"> • Three times the individual participating deductible • Three times the family participating deductible
Out-of-pocket maximum	<ul style="list-style-type: none"> • individual • family 	<ul style="list-style-type: none"> • per calendar year • deductibles and copayments do not apply 	<ul style="list-style-type: none"> • Not applicable • Not applicable 	<ul style="list-style-type: none"> • \$4,000 • \$8,000
Preventive care	<ul style="list-style-type: none"> • preventive services do not reduce the \$500 up-front benefit allowance 	<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) 	<ul style="list-style-type: none"> • 100% after office visit copayment • 100% • 100% after deductible 	<ul style="list-style-type: none"> • 70% after deductible • 70% after deductible • 70% after deductible
Physician services		<ul style="list-style-type: none"> • office visits • diagnostic lab and X-ray • allergy testing • injections and serums (including allergy) • inpatient and outpatient services • surgery • emergency room visits 	<ul style="list-style-type: none"> • 100% after office visit copayment and deductible • 100% after deductible • 100% after \$5 copayment per visit and deductible • 100% after deductible • 100% after deductible 	<ul style="list-style-type: none"> • 70% after deductible • 70% after deductible • 70% after deductible • 70% after deductible • 100% after participating deductible
Facility services		<ul style="list-style-type: none"> • inpatient services • outpatient surgery • outpatient services • outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)—hospital, freestanding facility and clinic • emergency services (copayment waived if admitted) 	<ul style="list-style-type: none"> • 100% after \$250 copayment per confinement and deductible • 100% after \$50 copayment per visit and deductible • 100% after deductible • 100% after \$150 copayment per visit and deductible 	<ul style="list-style-type: none"> • 70% after \$250 copayment per confinement and deductible • 70% after \$50 copayment per visit and deductible • 70% after deductible • 100% after \$150 copayment per visit and participating deductible
Other medical services		<ul style="list-style-type: none"> • skilled nursing facility (up to 60 days per calendar year) • hospice • home health care (up to 100 visits per calendar year) • physical, occupational, cognitive, speech and audiology therapy (combined limit up to 80 visits per calendar year) • urgent care • spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year) • durable medical equipment (limited to \$2,500 of covered services per calendar year) • ambulance • maternity 	<ul style="list-style-type: none"> • 100% after deductible • 100% after specialist copayment per visit and deductible • 100% after deductible • 100% after deductible • Same as any other illness 	<ul style="list-style-type: none"> • 70% after deductible • 70% after deductible • 70% after deductible • 100% after participating deductible • Same as any other illness

Humana CoverageFirst 08 Choice POS Illinois 100/70 Plan

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Other medical services (continued)	<ul style="list-style-type: none"> transplant services 	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
Lifetime maximum benefit			\$5,000,000
Mental health and chemical dependency	<ul style="list-style-type: none"> inpatient services (combined mental health and chemical dependency limit up to 10 days per calendar year) 	100% after \$250 copayment per confinement and deductible	70% after \$250 copayment per confinement and deductible
	<ul style="list-style-type: none"> outpatient and office therapy sessions (combined mental health and chemical dependency limit up to 15 visits per calendar year) 	100% after specialist copayment and participating deductible	70% after deductible
Alcohol dependency services	<ul style="list-style-type: none"> inpatient services 	Same as any other illness	Same as any other illness
	<ul style="list-style-type: none"> 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

☐ 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 largest, most cost-effective physician and hospital networks in the nation, including 530,000 providers and 4,000 hospitals across all 50 states.

Pharmacy options

Detailed drug lists are available at 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%
Mail order (up to 90-day supply)	2.5 times the retail copayment			
Copayment maximum (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 70 percent after applicable copayment.

Rx3

Retail (30-day supply)	Level 1	Level 2	Level 3
› Option 1	\$15	\$30	\$50
› Option 2	\$20	\$40	\$65
Mail order (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*
Mail order (up to 90-day supply)	—Up to three times applicable allowance amount	
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 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 employer. Premiums and benefits vary based on the plan selected.