

Illinois Plan 75, Option 011

		Plan pays for services from PARTICIPATING providers
Office visit copay		• \$35 primary care/\$65 specialist
Copay limits	Individual	\$3,000
	Family	\$6,000
Preventive care		
• immunizations (except for travel)		100%
• preventive office visits		100% after office visit copay
• preventive lab and X-ray		
• Pap smear and mammogram		
• prostate screening		
• endoscopic services (including, but not limited to colonoscopy)		
Physician services - most visits to specialists must be authorized by a primary care physician		
• office visits		100% after office visit copay
• prenatal care (copayment applies to first visit only)		
• diagnostic lab and X-ray (performed in office and billed by physician)		
• allergy testing		
• surgery performed in a physician's office		70%
• inpatient services		100%
• outpatient services		
• emergency room visits		
• allergy injections		100% after \$5 copay per visit
Facility services		
• inpatient services		70%
• outpatient nonsurgical care		70%
• outpatient surgical care (includes ambulatory surgical center)		70% after \$500 copay
• emergency services (copay waived if admitted)		100% after \$250 copay
Other medical services		
• advanced imaging (PET, MRI, MRA, CAT, SPECT)		70%
• hospice		
• skilled nursing facility (limited to 100 days per calendar year)		
• durable medical equipment		
• ambulance		
• physical, occupational, cognitive, speech and audiology therapy (combined limit to 60 visits per calendar year)		100% after specialist copay
• spinal manipulations, adjustments and modalities (combined limit to 20 visits per calendar year)		
• home health care (up to 60 visits per calendar year)		70%
• maternity		Same as any other illness
• transplant services		
Lifetime maximum benefit		Unlimited
Mental health¹		
• inpatient services (limited to 30 days per calendar year)		70%
• outpatient and office therapy sessions (limited to 20 visits per calendar year)		100% after specialist copay
Alcohol and chemical dependency¹		
• inpatient services (combined limit to 30 days per calendar year)		70%
• outpatient and office therapy sessions (combined limit to 20 visits per calendar year)		100% after specialist copay

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.

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)
	\$10	\$45	\$70	25%	2.5 times the retail copayment

NOTE: If a nonparticipating pharmacy is used, there is no coverage.

* 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)
	\$10	\$40	\$60	2.5 times the retail copayment

NOTE: If a nonparticipating pharmacy is used, there is no coverage.

Limitations and exclusions

This is a partial list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Certificate of Coverage for this complete listing. The Certificate of Coverage is the document upon which benefit payment will be determined.

Unless stated otherwise, no coverage will be provided for the following situations.

- Care for conditions that state or local law requires to be treated in a public facility.
- Experimental drugs or substances not approved by us or by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications or drugs labeled: "Caution-limited by federal law to investigational use."
- Drugs or medicines, prescription or nonprescription, provided to the member while he or she is not hospital confined, unless otherwise covered by a Prescription Drug Benefit Rider attached to the Group Plan.
- Any service, supply, care or treatment that is not described in the Health Services Agreement or any rider attached to and made a part of the Group Plan.
- Any service, supply, care or treatment provided to the member without the authorization of his or her primary care physician, unless the member is receiving emergency services or care from a participating woman's principal health care provider who is in the same medical group as the member's primary care physician.
- The purchase or fitting of hearing aids, eyeglasses, contact lenses or advice on their care; except the first pair of eyeglasses or contacts needed due to cataract surgery or an accident.
- Biomicroscopy, field charting or aniseikonic investigation.
- Reversal of elective sterilization or sexual reassignment surgery.
- Any drug, biological product, device, medical treatment or procedure which is experimental or investigational, as described in the Group Plan.
- Plastic, cosmetic or reconstructive surgery, except as specified in the Group Plan.
- Services and supplies for dental care, including dental appliances; treatment of the teeth or periodontium or oral surgery, except as described in the Group Plan.
- Services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction unless such services are medically necessary as determined by the member's primary care physician and authorized on a prospective and timely basis by the HMO's medical director.
- Care and treatment of feet unless such services are medically necessary as determined by member's primary care physician.
- A physical examination which would result in a duplication of benefits.
- Any service, supply or treatment connected with custodial care.
- Any treatment to reduce obesity including, but not limited to, surgical procedures, unless medically necessary.

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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.