

**Illinois  
Plan 75, Option 002**

Plan pays for services provided or arranged by your **PARTICIPATING** primary care physician

<b>Preventive care</b>	<ul style="list-style-type: none"> <li>immunizations (except for travel)</li> <li>preventive office visits</li> <li>preventive lab and X-ray</li> <li>Pap smear and mammogram</li> <li>prostate screening</li> <li>endoscopic services (including, but not limited to colonoscopy)</li> </ul>	<p>100%</p> <p>100% after \$15 primary care physician or \$25 specialist copayment per visit</p>
<b>Physician services</b> Most visits to specialists must be authorized by a primary care physician.	<ul style="list-style-type: none"> <li>office visits</li> <li>prenatal care (copayment applies to first visit only)</li> <li>diagnostic lab and X-ray</li> <li>allergy testing</li> <li>surgery performed in a physician's office</li> <li>inpatient and outpatient services</li> <li>allergy injections and serums</li> <li>emergency room visits</li> </ul>	<p>100% after \$15 primary care physician or \$25 specialist copayment per visit</p> <p>100%</p>
<b>Facility services</b>	<ul style="list-style-type: none"> <li>inpatient services</li> <li>outpatient non-surgical care</li> <li>outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) —hospital, freestanding facility and clinic</li> <li>outpatient surgical care (includes ambulatory surgical center)</li> <li>emergency services (copayment waived if admitted)</li> </ul>	<p>100% after \$250 copayment per day for the first three days</p> <p>100% after \$100 copayment per visit</p> <p>100% after \$200 copayment per visit</p> <p>100% after \$75 copayment per visit</p>
<b>Other medical services</b>	<ul style="list-style-type: none"> <li>physical, occupational, cognitive, speech and audiology therapy (up to 60 visits per calendar year)</li> <li>spinal manipulations, adjustments and modalities (up to 20 visits per calendar year)</li> <li>skilled nursing facility (up to 100 days per calendar year)</li> <li>hospice</li> <li>home health care (up to 60 visits per calendar year)</li> <li>durable medical equipment</li> <li>ambulance</li> <li>maternity</li> <li>transplant services</li> </ul>	<p>100% after \$25 copayment per visit</p> <p>100%</p> <p>Same as any other illness</p>
<b>Lifetime maximum benefit</b>		Unlimited
<b>Mental health, chemical and alcohol dependency</b>	<ul style="list-style-type: none"> <li>inpatient services (up to 30 days per calendar year)</li> <li>outpatient &amp; office therapy sessions (up to 20 visits per calendar year)</li> </ul>	<p>100% after \$250 copayment per day for the first three days</p> <p>100% after \$25 copayment per visit</p>
<b>Copayment limits</b>	<ul style="list-style-type: none"> <li>individual</li> <li>family</li> </ul>	<p>\$1,500</p> <p>\$3,000</p>

## 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	\$5	\$15	\$35	25%
> Option 2	\$10	\$20	\$40	25%
> Option 3	\$10	\$25	\$45	25%
<b>Mail order</b> (up to 90-day supply)	3 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, there is no coverage.

### Rx3

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

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

## Service area counties

- > Cook                    > Lake
- > Du Page                > McHenry
- > Kane                    > Will
- > Kankakee

## 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.

1. Care for conditions that state or local law requires to be treated in a public facility.
2. 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."
3. 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.
4. 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.
5. 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.
6. 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.
7. Biomicroscopy, field charting or aniseikonic investigation.
8. Reversal of elective sterilization or sexual reassignment surgery.
9. Any drug, biological product, device, medical treatment or procedure which is experimental or investigational, as described in the Group Plan.
10. Plastic, cosmetic or reconstructive surgery, except as specified in the Group Plan.
11. 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.
12. 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.
13. Care and treatment of feet unless such services are medically necessary as determined by member's primary care physician.
14. A physical examination which would result in a duplication of benefits.
15. Any service, supply or treatment connected with custodial care.
16. Any treatment to reduce obesity including, but not limited to, surgical procedures, unless medically necessary.

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Offered by Humana Health Plan, Inc.

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.