

## 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> <li>• family</li> </ul>	<ul style="list-style-type: none"> <li>• \$250/\$500/\$1,000/\$1,500/\$2,000</li> <li>• \$2,500/\$3,000/\$4,000/\$5,000</li> </ul>	Three times the individual participating deductible
<ul style="list-style-type: none"> <li>• per calendar year</li> <li>• copayments do not apply</li> </ul>		<ul style="list-style-type: none"> <li>• \$500/\$1,000/\$2,000/\$3,000/\$4,000</li> <li>• \$5,000/\$6,000/\$8,000/\$10,000</li> </ul>	Three times the family participating deductible
<b>Out-of-pocket maximum options</b>	<ul style="list-style-type: none"> <li>• individual</li> <li>• family</li> </ul>	<ul style="list-style-type: none"> <li>• \$1,000/\$2,000/\$3,000</li> <li>• \$2,000/\$4,000/\$6,000</li> </ul>	Three times the individual participating out-of-pocket max
<ul style="list-style-type: none"> <li>• per calendar year</li> <li>• deductibles and copayments do not apply</li> </ul>			Three times the family participating out-of-pocket max
<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> <li>• endoscopic services (including, but not limited to colonoscopy)</li> </ul>	<ul style="list-style-type: none"> <li>100% after office visit copayment</li> <li>100%</li> <li>90% after deductible</li> </ul>	<ul style="list-style-type: none"> <li>60% after deductible</li> <li>60% after deductible</li> <li>60% after deductible</li> </ul>
<b>Physician services</b>	<ul style="list-style-type: none"> <li>• office visits</li> <li>• diagnostic lab and X-ray</li> <li>• allergy testing</li> <li>• injections and serums (including allergy)</li> <li>• inpatient and outpatient services</li> <li>• surgery</li> <li>• emergency room visits</li> </ul>	<ul style="list-style-type: none"> <li>100% after office visit copayment</li> <li>100%</li> <li>100% after \$5 copayment per visit</li> <li>90% after deductible</li> <li>100%</li> </ul>	<ul style="list-style-type: none"> <li>60% after deductible</li> <li>60% after deductible</li> <li>60% after deductible</li> <li>60% after deductible</li> <li>100%</li> </ul>
<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> <li>• emergency services (copayment waived if admitted)</li> </ul>	<ul style="list-style-type: none"> <li>90% after deductible</li> <li>100% after \$150 copayment</li> </ul>	<ul style="list-style-type: none"> <li>60% after deductible</li> <li>100% after \$150 copayment</li> </ul>
<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> <li>• urgent care</li> <li>• spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year)</li> <li>• durable medical equipment (limited to \$2,500 of covered services per calendar year)</li> <li>• ambulance</li> <li>• maternity</li> <li>• transplant services</li> </ul>	<ul style="list-style-type: none"> <li>90% after deductible</li> <li>100% after specialist copayment per visit</li> <li>90% after deductible</li> <li>90% after deductible</li> <li>Same as any other illness</li> <li>Same as any other illness when services are received from a Humana Transplant Network provider</li> </ul>	<ul style="list-style-type: none"> <li>60% after deductible</li> <li>60% after deductible</li> <li>60% after deductible</li> <li>90% after participating deductible</li> <li>Same as any other illness</li> <li>Same as any other illness. Covered expenses are limited to a maximum benefit of \$35,000 per transplant</li> </ul>
<b>Lifetime maximum benefit</b>			\$5,000,000
<b>Mental health and chemical dependency</b>	<ul style="list-style-type: none"> <li>• inpatient services (combined limit up to 10 days per calendar year)</li> <li>• outpatient &amp; office therapy sessions (combined limit up to 15 visits per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>90% after deductible</li> <li>100% after specialist office visit copayment</li> </ul>	<ul style="list-style-type: none"> <li>60% after deductible</li> <li>60% after deductible</li> </ul>

**Humana ChoicePOS 08  
Illinois 90/60 Copay plan**

Plan pays for services from  
**PARTICIPATING** providers

Plan pays for services from  
**NONPARTICIPATING** providers

<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**

**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](http://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 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
<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.



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.