HumanaPPO 10

HUMANA
Guidance when you need it most

Illinois 90/60 Copay plan

		Plan pays for services from **PARTICIPATING** providers	Plan pays for services from **NONPARTICIPATING** providers
Office visit and urgent care copay options		• $25 primary care/$55 specialist/ $75 urgent care • $35 primary care/$75 specialist/ $100 urgent care	Not applicable
Deductible options • per calendar year • copays do not apply	**Individual**	$500/$1,000/$1,500/$2,000/ $2,500/$3,000/$5,000	$1,500/$3,000/$4,500/$6,000/ $7,500/$9,000/$15,000
	Family	$1,000/$2,000/$3,000/$4,000/ $5,000/$6,000/$10,000	$3,000/$6,000/$9,000/$12,000/ $15,000/$18,000/$30,000
Out-of-pocket maximum • per calendar year • deductibles and copays do not apply	**Individual**	$2,000/$4,000	$6,000/$12,000
	Family	$4,000/$8,000	$12,000/$24,000
Preventive care			
• 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)		100%	60% after deductible
Physician services			
• office visits		100% after office visit copay	60% after deductible
• diagnostic lab and X-ray (performed in office and billed by physician) • allergy testing		100%	60% after deductible
• injections (including allergy)		100% after $5 copay	60% after deductible
• inpatient services • outpatient services • surgery		90% after deductible	60% after deductible
• emergency room visits		100%	100%
Facility services			
• inpatient services • outpatient services • outpatient diagnostic lab and X-ray • outpatient surgery		90% after deductible	60% after deductible
• emergency services (copay waived if admitted)		100% after $250 copay	100% after $250 copay
Other medical services			
• retail clinic		100% after primary care copay	60% after deductible
• urgent care		100% after urgent care copay	60% after deductible
• spinal manipulations, adjustments, and modalities (combined limit to 20 visits per calendar year)		100% after specialist copay	60% after deductible
• physical, occupational, cognitive, speech and audiology therapy (combined limit to 80 visits per calendar year) • advanced imaging (PET, MRI, MRA, CAT, SPECT) • hospice • home health care (limited to 100 visits per calendar year) • skilled nursing facility (limited to 60 days per calendar year)		90% after deductible	60% after deductible
• ambulance		90% after deductible	90% after participating deductible
• maternity		Same as any other illness	Same as any other illness
• transplant services		Same as any other illness when services are received from a Humana Transplant Network provider	Same as any other illness. Benefits payable will not exceed the non-network benefit limit of $35,000 per covered organ transplant
Mental health and chemical dependency[1]			
• inpatient services (combined mental health and chemical dependency limit to 10 days per calendar year)		90% after deductible	60% after deductible
• outpatient and office therapy sessions (combined mental health, chemical and alcohol dependency limit to 15 visits per calendar year)		100% after specialist copay	60% after deductible
Alcohol dependency			
• inpatient services		Same as any other illness	Same as any other illness

[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.

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Network

Humana/ChoiceCare Network® (CHC)

Humana's ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, and it's growing daily. As of February 1, 2010, our ChoiceCare Network includes 583,000 providers and 3,900 hospitals across all 50 states. This PPO network gives employees coast-to-coast access to favorably priced health care. Plus, Humana maintains strong provider relationships with local PPO networks for added coverage.

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, the claim is covered at 70 percent after applicable copayment.
* 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, the claim is covered at 70 percent after applicable copayment.

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Insured by Humana Insurance Company

This plan imposes a pre-existing condition exclusion. 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.