

# Create a customized plan summary

**Step 1: Choose the benefit options** selected by the employer from the menu below.  
To make this a valid plan summary, the options selected must match the Humana quote.

**Step 2: View and print your plan summary** by scrolling to the pages that follow.

**Step 3: Saving your plan summary.** You must have the full version of Adobe Acrobat  
(not Acrobat Reader) in order to save your plan summary to your PC.

## Build your plan:

Enter customer name:

Select your office visit copayment:

Pick your deductible:

Choose your out-of-pocket maximum:

Select your pharmacy benefit:

## Michigan 90/60 Copay plan

Plan pays for services from  
**PARTICIPATING** providers

Plan pays for services from  
**NONPARTICIPATING** providers

Office visit copayment			
<b>Deductible</b>	<ul style="list-style-type: none"> <li>individual</li> </ul>		
<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>family</li> </ul>		
<b>Out-of-pocket maximum</b>	<ul style="list-style-type: none"> <li>individual</li> </ul>		
<ul style="list-style-type: none"> <li>per calendar year</li> <li>deductibles and copayments do not apply</li> </ul>	<ul style="list-style-type: none"> <li>family</li> </ul>		
<b>Preventive care</b>	<ul style="list-style-type: none"> <li>preventive office visits</li> </ul>	100% after office visit copayment	60% after deductible
	<ul style="list-style-type: none"> <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> </ul>	100%	60% after deductible
	<ul style="list-style-type: none"> <li>endoscopic services (including, but not limited to colonoscopy)</li> </ul>	90% after deductible	60% after deductible
<b>Physician services</b>	<ul style="list-style-type: none"> <li>office visits</li> </ul>	100% after office visit copayment	60% after deductible
	<ul style="list-style-type: none"> <li>diagnostic lab and X-ray</li> <li>allergy testing</li> </ul>	100%	60% after deductible
	<ul style="list-style-type: none"> <li>injections and serums (including allergy)</li> </ul>	100% after \$5 copayment per visit	60% after deductible
	<ul style="list-style-type: none"> <li>inpatient and outpatient services</li> <li>surgery</li> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>emergency room visits</li> </ul>	100%	100%
<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> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>emergency services (copayment waived if admitted)</li> </ul>	100% after \$150 copayment	100% after \$150 copayment
<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 25 visits per calendar year)</li> <li>durable medical equipment (limited to \$2,500 of covered services per calendar year)</li> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>urgent care</li> <li>spinal manipulations, adjustments and modalities (combined limit up to 20 visits per calendar year)</li> </ul>	100% after specialist copayment per visit	60% after deductible
	<ul style="list-style-type: none"> <li>ambulance</li> </ul>	90% after deductible	90% after participating deductible
	<ul style="list-style-type: none"> <li>maternity</li> </ul>	Same as any other illness	Same as any other illness
	<ul style="list-style-type: none"> <li>transplant services</li> </ul>	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 allowance of \$35,000 per transplant
<b>Lifetime maximum benefit</b>			\$5,000,000
<b>Mental health, chemical and alcohol dependency</b>	<ul style="list-style-type: none"> <li>inpatient services (up to 10 days per calendar year)</li> </ul>	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> <li>mental health outpatient and office therapy sessions (up to 15 visits per calendar year)</li> <li>chemical and alcohol dependency outpatient and office therapy sessions (subject to US Consumer Price Index)</li> </ul>	100% after specialist office visit copayment	60% after deductible

## Network

### **PPOM/ChoiceCare Network® (PPOM/CHC)**

Humana's ChoiceCare Network is one of the largest, most cost-effective physician and hospital networks in the nation, including 455,000 providers and 3,750 hospitals across all 50 states.

## Pharmacy

Detailed drug lists are available at [www.humana.com](http://www.humana.com) for each pharmacy plan and level.



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.