

Humana Insurance Company

Name of Carrier

**HumanaOne Enhanced Copay 80%**

Name of Individual Health Plan

**Part A: Type of Coverage**

|                                              |                                                        |
|----------------------------------------------|--------------------------------------------------------|
| 1. Type of plan                              | Preferred Provider Plan                                |
| 2. Out-of-network care covered? (1)          | Yes, but the patient pays more for out-of-network care |
| 3. Areas of Colorado where plan is available | <b>Plan is available throughout Colorado</b>           |

**Part B: Summary of Benefits**

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

**Coinsurance and copayment options reflect the amount the covered person will pay**

|                                                                                                                           | <b>In-Network</b>                                                                         | <b>Out-of-Network</b>                                            |
|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 4. Deductible Type (2)                                                                                                    | Calendar Year                                                                             | Calendar Year                                                    |
| 4A. Annual deductible (2a)                                                                                                |                                                                                           |                                                                  |
| a. Individual (2b)                                                                                                        |                                                                                           |                                                                  |
| b. Family (2c)                                                                                                            |                                                                                           |                                                                  |
|                                                                                                                           | Three family members must meet their individual deductible                                |                                                                  |
| 5. Out-of-pocket annual maximum (3)                                                                                       |                                                                                           |                                                                  |
| a. Individual                                                                                                             | \$2,500                                                                                   | \$10,000                                                         |
| b. Family                                                                                                                 | \$5,000                                                                                   | \$20,000                                                         |
| c. Is deductible included in the out-of-pocket maximum?                                                                   | Does not include deductible or copayments                                                 |                                                                  |
| 6. Lifetime benefit maximum paid by the plan for all care                                                                 | Unlimited                                                                                 |                                                                  |
| 7A. Covered providers                                                                                                     | Humana/ChoiceCare® network See provider directory for complete list of current providers. | All providers licensed or certified to provide covered benefits. |
| 7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician? | Not applicable                                                                            | Not applicable                                                   |

|                                                                                                                                                                                                                                                         |                                                                                                                                 | In-Network           | Out-of-Network |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------|
| 8. Medical office visits (4)                                                                                                                                                                                                                            |                                                                                                                                 |                      |                |
| a. Primary care providers<br>Primary care providers include family practitioner, general practitioner, gynecologist, pediatrician, internist, nurse practitioner, Physician Assistant or Registered Nurse; Please contact Customer Service for details. | 0% after \$35 copayment<br>(Copayments do not apply to the deductible or out-of-pocket maximum.)                                | 40% after deductible |                |
| b. Specialists<br>Specialist contains any other participating physician. Please contact Customer Service for details.                                                                                                                                   | 0% after \$60 copayment<br>(Copayments do not apply to the deductible or out-of-pocket maximum.)                                | 40% after deductible |                |
| 9. Preventive care                                                                                                                                                                                                                                      |                                                                                                                                 |                      |                |
| a. Children's services                                                                                                                                                                                                                                  |                                                                                                                                 |                      |                |
| 1. Exams and labs (birth to age 13)                                                                                                                                                                                                                     | 0% no deductible                                                                                                                | 40% no deductible    |                |
| 2. Exams and labs (age 13 to age 18)                                                                                                                                                                                                                    | 0% no deductible                                                                                                                | 40% after deductible |                |
| 3. Preventive X-ray (birth to age 18)                                                                                                                                                                                                                   | 0% no deductible                                                                                                                | 40% after deductible |                |
| 4. Immunizations (birth to age 18)                                                                                                                                                                                                                      | 0% no deductible                                                                                                                | 0% no deductible     |                |
| b. Adult services                                                                                                                                                                                                                                       |                                                                                                                                 |                      |                |
| 1. Routine lab, pathology and X-ray (EXCEPT cholesterol screening for lipid disorders)                                                                                                                                                                  | 0% no deductible                                                                                                                | 40% after deductible |                |
| 2. Cholesterol screening for lipid disorders                                                                                                                                                                                                            | 0% no deductible                                                                                                                | 0% no deductible     |                |
| 3. Routine Pap (Cervical cancer screening)                                                                                                                                                                                                              | 0% no deductible                                                                                                                | 0% no deductible     |                |
| 4. Routine mammogram                                                                                                                                                                                                                                    | 0% no deductible                                                                                                                | 0% no deductible     |                |
| 5. Annual routine PSA and digital rectal exam (up to age 40)                                                                                                                                                                                            | 0% no deductible                                                                                                                | 40% after deductible |                |
| 6. Annual routine PSA and digital rectal exam (age 40 and older)                                                                                                                                                                                        | 0% no deductible                                                                                                                | 40% no deductible    |                |
| 7. Adult preventive flu/pneumonia immunization                                                                                                                                                                                                          | 0% no deductible                                                                                                                | 0% no deductible     |                |
| c. Colorectal screening services                                                                                                                                                                                                                        |                                                                                                                                 |                      |                |
| 1. Preventive endoscopic services (preventive colonoscopy, sigmoidoscopy and proctosigmoidoscopy)                                                                                                                                                       | 0% no deductible                                                                                                                | 0% no deductible     |                |
| 2. Colorectal cancer screening                                                                                                                                                                                                                          | 0% no deductible                                                                                                                | 0% no deductible     |                |
| 10. Maternity                                                                                                                                                                                                                                           |                                                                                                                                 |                      |                |
| a. Prenatal care                                                                                                                                                                                                                                        | 0% after \$35 copayment for PCP or \$60 for specialist<br>(Copayments do not apply to the deductible or out-of-pocket maximum.) | 40% after deductible |                |
| b. Delivery and inpatient well-baby care (5)                                                                                                                                                                                                            | 20% after deductible                                                                                                            | 40% after deductible |                |

|                                                                                                                                                                                                                                                                                                                        | In-Network                                                                                                                                                                                   | Out-of-Network                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 11. Prescriptions drugs (6)                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                              |                                                                                      |
| a. Annual deductible (separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)                                                                                                                                                                                                    |                                                                                                                                                                                              |                                                                                      |
| b. Each prescription or refill (up to 30-day supply)                                                                                                                                                                                                                                                                   | 0% after:                                                                                                                                                                                    | 30% after:                                                                           |
| Level One                                                                                                                                                                                                                                                                                                              | \$15 copayment                                                                                                                                                                               | \$15 copayment                                                                       |
| Level Two                                                                                                                                                                                                                                                                                                              | \$35 copayment after prescription drug deductible                                                                                                                                            | \$35 copayment after prescription drug deductible                                    |
| Level Three                                                                                                                                                                                                                                                                                                            | \$60 copayment after prescription drug deductible                                                                                                                                            | \$60 copayment after prescription drug deductible                                    |
| Level Four                                                                                                                                                                                                                                                                                                             | 35% copayment after deductible up to \$5,000 maximum out-of-pocket per calendar year                                                                                                         | 35% copayment after deductible up to \$5,000 maximum out-of-pocket per calendar year |
| Mail order (90-day supply)                                                                                                                                                                                                                                                                                             | Three times the retail copayment                                                                                                                                                             | Three times the retail copayment                                                     |
| 12. Inpatient hospital                                                                                                                                                                                                                                                                                                 | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
| 13. Outpatient hospital/ambulatory surgery                                                                                                                                                                                                                                                                             | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
| 14. Diagnostics                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                              |                                                                                      |
| a. Laboratory and X-ray - includes interpretation excludes MRI, CAT, EEG, EKG, ECG, cardiac catheterization, endoscopic services, and pulmonary function studies                                                                                                                                                       | First \$500 per calendar year paid at 100% per person, then 20% after deductible<br>The first \$500 is a combined In-network benefit max to include diagnostic lab/test/x-ray/interpretation | 40% after deductible                                                                 |
| b. MRI, nuclear medicine, and other high-tech services                                                                                                                                                                                                                                                                 | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
| 15. Emergency room (7), (8)                                                                                                                                                                                                                                                                                            | 20% after \$100 access fee per visit and deductible (copayment waived if admitted)                                                                                                           | 20% after \$100 access fee per visit and deductible (copayment waived if admitted)   |
| 16. Ambulance                                                                                                                                                                                                                                                                                                          | 20% after deductible                                                                                                                                                                         | 20% after deductible                                                                 |
| 17. Urgent, non routine after hours care                                                                                                                                                                                                                                                                               | 0% after \$60 copayment (Copayments do not apply to the deductible or out-of-pocket maximum.)                                                                                                | 40% after deductible                                                                 |
| 18. Biologically based mental illness care (9)                                                                                                                                                                                                                                                                         | See #19, Other mental health care                                                                                                                                                            |                                                                                      |
| 19. Other mental health care—There is a separate Mental Health deductible from the plan deductible. The value is equal to the plan single/family, In-network/ Out-of-network deductible values. The Mental Health deductible does not accumulate to the In-network or Out-of-network plan deductible or out-of-pocket. |                                                                                                                                                                                              |                                                                                      |
| a. Inpatient care                                                                                                                                                                                                                                                                                                      | 50% after mental health deductible                                                                                                                                                           | 50% after mental health deductible                                                   |
| b. Outpatient care                                                                                                                                                                                                                                                                                                     | 50% after mental health deductible                                                                                                                                                           | 50% after mental health deductible                                                   |
| 20. Alcohol and substance abuse                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                              |                                                                                      |
| a. Inpatient care                                                                                                                                                                                                                                                                                                      | See #19, Other mental health care                                                                                                                                                            | See #19, Other mental health care                                                    |
| b. Outpatient care                                                                                                                                                                                                                                                                                                     | See #19, Other mental health care                                                                                                                                                            | See #19, Other mental health care                                                    |
| 21. Physical, occupational, and speech therapy                                                                                                                                                                                                                                                                         | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
|                                                                                                                                                                                                                                                                                                                        | 30 visit limit combined with cognitive, respiratory, cardiac, and audiology therapy                                                                                                          |                                                                                      |
| 22. Durable medical equipment                                                                                                                                                                                                                                                                                          | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
| 23. Oxygen                                                                                                                                                                                                                                                                                                             | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
| 24. Organ transplants                                                                                                                                                                                                                                                                                                  | 20% after deductible (when services are at a National Transplant Network provider)                                                                                                           | 40% after deductible (limited to \$35,000 per covered transplant)                    |
| 25. Home health care                                                                                                                                                                                                                                                                                                   | 20% after deductible                                                                                                                                                                         | 40% after deductible                                                                 |
|                                                                                                                                                                                                                                                                                                                        | Limited to 60 visits per calendar year                                                                                                                                                       |                                                                                      |

|                                                                                                     | In-Network                                                                                                                                                                                                                                               | Out-of-Network            |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 26. Hospice care                                                                                    | 20% after deductible                                                                                                                                                                                                                                     | 40% after deductible      |
|                                                                                                     | Bereavement limited to \$1,150 per family for the 12 month period following death; counseling for hospice patient and immediate family is limited to 15 visits per family per lifetime; medical social services limited to \$100 per family per lifetime |                           |
| 27. Skilled nursing facility care                                                                   | 20% after deductible                                                                                                                                                                                                                                     | 40% after deductible      |
|                                                                                                     | Up to 30 days per calendar year                                                                                                                                                                                                                          |                           |
| 28. Dental care                                                                                     | 20% after deductible                                                                                                                                                                                                                                     | 40% after deductible      |
|                                                                                                     | For injury and for outpatient hospital and anesthesia for a covered dependent                                                                                                                                                                            |                           |
| 29. Vision care                                                                                     | No coverage                                                                                                                                                                                                                                              | No coverage               |
| 30. Spinal manipulations, modalities, & adjustments                                                 | 20% after deductible                                                                                                                                                                                                                                     | 40% after deductible      |
|                                                                                                     | 10 visits per calendar year                                                                                                                                                                                                                              |                           |
| 31. Significant additional covered services                                                         |                                                                                                                                                                                                                                                          |                           |
| a. Cure and treatment of cleft lip and palate                                                       | Same as any other illness                                                                                                                                                                                                                                | Same as any other illness |
| b. Diabetes equipment and supplies and treatment/self management training and education             | 20% after deductible                                                                                                                                                                                                                                     | 40% after deductible      |
| c. Hearing aids (under age 18)                                                                      | Same as any other illness                                                                                                                                                                                                                                | Same as any other illness |
| d. Optional supplemental accident benefit (treatment must be provided within 90 days of the injury) |                                                                                                                                                                                                                                                          |                           |

## Part C: Limitations and Exclusions

|                                                                                                                        |                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 32. Period during which pre-existing conditions are not covered. (10)                                                  | Twelve months for all pre-existing conditions unless the covered person is a HIPAA eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions. The pre-existence condition limitation does not apply to a covered person who is under the age of 19. |
| 33. Exclusionary riders.<br>Can an individual's specific, pre-existing condition be entirely excluded from the policy? | Yes, unless the individual is a HIPAA eligible individual as defined under federal and state law.                                                                                                                                                                                                                  |
| 34. How does the policy define a "pre-existing condition"?                                                             | A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.                                              |
| 35. What treatments and conditions are excluded under this policy?                                                     | Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.                                                                          |

## Part D: Using the Plan

|                                                                                                                                                                      | In-Network                                                                                                         | Out-of-Network |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------|
| 36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?                                                  | No                                                                                                                 | No             |
| 37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?                                                              | Yes                                                                                                                | Yes            |
| 38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?                                    | No                                                                                                                 | Yes            |
| 39. What is the main Customer Service number?                                                                                                                        | 1-800-833-6917                                                                                                     |                |
| 40. Whom do I write/call if I have a complaint or want to file a grievance? (11)                                                                                     | Write to: Humana Grievance & Appeals Office<br>P.O. Box 14616<br>Lexington, KY 40512-4616<br>Phone: 1-800-833-6917 |                |
| 41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?                                                                        | Write to: Colorado Division of Insurance<br>ICARE Section<br>1560 Broadway, Suite 850<br>Denver, CO 80202          |                |
| 42. To assist in filing a grievance, indicate the form number of this policy whether it is individual, small group, or large group and if it is a short-term policy. | Policy form # GN-71037-01 4/2010, et al., individual                                                               |                |
| 43. Does this plan have a binding arbitration clause?                                                                                                                | No                                                                                                                 |                |

## **Endnotes:**

- (1) "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- (2) "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".
- (2a) "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.
- (2b) "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
- (2c) "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3,000 per family) or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
- (3) "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.
- (4) Medical office visits include physician, mid-level practitioner, and specialist visits.
- (5) Well baby care includes an in-hospital newborn pediatric visit.
- (6) Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.
- (7) "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- (8) Nonemergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician.
- (9) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder.
- (10) Waiver of pre-existing conditions exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
- (11) Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.



Insured by Humana Insurance Company

Local Contact at Regional Office

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Local: 303-694-1044 • Toll-Free: 800-825-7496

**Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.**