



## Colorado Health Plan Description Form Humana Insurance Company 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>

Humana Insurance Company  
Local Contact at Regional Office  
8400 East Prentice Avenue, Suite 1400  
Englewood, CO 80111-2926  
Local: 303-694-1044  
Toll-Free: 800-825-7496



Insured by Humana Insurance Company

**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. Annual deductible (2) a. Individual b. Family	See benefit schedule attached	
5. Out-of-pocket annual maximum (3) a. Individual	\$2,000	\$8,000
b. Family	Must be satisfied by each individual covered person	Must be satisfied by each individual covered person
c. Does not include deductible or copayments		
6. Lifetime benefit maximum paid by the plan for all care	\$5,000,000 <i>(combined in and out of network)</i>	
7. A. Covered providers	ChoiceCare network See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7. B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable	Not applicable
8. Routine medical office visits (4) a. Primary Care Providers b. Specialists	<b>20%</b> after deductible <b>20%</b> after deductible	<b>40%</b> after deductible <b>40%</b> after deductible
9. Preventive care a. Children's services including exams and immunizations <i>(birth to age 13)</i> b. Adult services 1. Annual routine PSA and digital rectal exam 2. Routine immunizations <i>(age 13 to 18) (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)</i> 3. Annual routine Pap smear, annual routine physical exam <i>(age 13 and older) (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)</i>	<b>20%</b> <b>20%</b> <b>20%</b>	<b>40%</b> <b>40%</b> Not covered Not covered

	IN-NETWORK	OUT-OF-NETWORK
4. Routine mammogram	<b>20%</b>	<b>40%</b>
5. Routine lab, pathology and X-ray <i>(up to a combined maximum of \$300 per person per calendar year subject to coinsurance)</i>	<b>20%</b> after deductible	Not covered
10. Maternity		
a. Prenatal care <i>(unless optional maternity rider is purchased)</i>	Not covered	Not covered
b. Delivery <i>(unless optional maternity rider is purchased)</i>	Not covered	Not covered
c. Inpatient well-baby care (5)	<b>20%</b> after deductible	<b>40%</b> after deductible
11. Prescription drugs (6)		
a. Annual deductible <i>(separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)</i>	\$500 per individual	\$500 per individual
b. Each prescription or refill <i>(up to 30-day supply)</i> :	<b>0%</b> after:	<b>30%</b> after:
- Level One	\$10 copayment after deductible	\$10 copayment after deductible
- Level Two	\$30 copayment after deductible	\$30 copayment after deductible
- Level Three	\$50 copayment after deductible	\$50 copayment after deductible
- Level Four	<b>25%</b> copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year	<b>25%</b> copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year
Mail order <i>(90-day supply)</i>	Three times the retail copayment	Three times the retail copayment
12. Inpatient hospital	<b>20%</b> after deductible	<b>40%</b> after deductible
13. Outpatient hospital/Ambulatory surgery	<b>20%</b> after deductible	<b>40%</b> after deductible
14. Diagnostics		
a. Laboratory and X-ray	<b>20%</b> after deductible	<b>40%</b> after deductible
b. MRI, nuclear medicine and other high-tech services	<b>20%</b> after deductible	<b>40%</b> after deductible
15. Emergency room <i>(including physician visits) (7), (8)</i>	<b>20%</b> after \$75 copayment per visit and deductible <i>(copayment waived if admitted)</i>	<b>40%</b> after \$75 copayment per visit and deductible <i>(copayment waived if admitted)</i>
16. Ambulance <i>(up to \$15,000 maximum per calendar year)</i>	<b>20%</b> after deductible	<b>20%</b> after deductible
17. Urgent, nonroutine after hours care	<b>20%</b> after deductible	<b>40%</b> after deductible
18. Biologically based mental illness (9)	Not applicable	Not applicable

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
19. Other mental health care a. Inpatient ( <i>up to \$2,500 maximum per calendar year for all mental health benefits</i> )  b. Outpatient therapy ( <i>up to \$500 maximum per calendar year for all mental health benefits. Outpatient Mental Health maximum reduces Inpatient Mental Health maximum</i> )	<b>50%</b> after deductible  <b>50%</b> after deductible	<b>50%</b> after deductible  <b>50%</b> after deductible
20. Alcohol and substance abuse a. Inpatient ( <i>up to \$2,500 maximum per calendar year for all mental health benefits</i> )  b. Outpatient therapy ( <i>up to \$500 maximum per calendar year for all mental health benefits</i> )	See #19, Other mental health care  See #19, Other mental health care	See #19, Other mental health care  See #19, Other mental health care
21. Physical, occupational and speech therapy ( <i>limited to a combined maximum of 20 visits per calendar year</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
22. Durable medical equipment ( <i>preauthorization required</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
23. Oxygen ( <i>preauthorization required</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
24. Organ transplants ( <i>preauthorization required</i> )	<b>20%</b> after deductible when services are at a National Transplant Network Provider	<b>40%</b> after deductible to separate out-of-pocket maximum of \$35,000 per calendar year
25. Home health care ( <i>preauthorization required; limited to 60 visits per calendar year</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
26. Hospice care ( <i>Preauthorization required; Bereavement limited to \$1,150 per family for the 12 month period following death; Nursing, social/counseling services, and certified nurses aid or delegated nursing services, limited to \$9,100 per member per benefit period</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
27. Skilled nursing facility care ( <i>Preauthorization required; up to 30 days per calendar year</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
28. Dental care ( <i>for injury and for outpatient hospital and anesthesia for a covered dependent</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
29. Vision care	No coverage	No coverage

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
30. Chiropractic care (see #21 for visit limitation)	<b>20%</b> after deductible	<b>40%</b> after deductible
31. Significant additional covered services a Cure and treatment of cleft lip and palate b Diabetes equipment and supplies and outpatient self-management training c Annual routine PSA and digital rectal exam for males 50 years of age or older, or over age 40 if in a high risk category. d Baseline mammogram for females between the ages of 35 and 40 and an annual mammogram for females 40 years of age or older.	<b>20%</b> after deductible	<b>20%</b> after deductible

**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.
33. Exclusionary riders. 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 them to see if a service or treatment you may need is excluded from the policy.

**PART D: USING THE PLAN**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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 P.O. Box 14616 Lexington, KY 40512-4616 Phone: 1-800-833-6317	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 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-70129 et al, individual	
43. Does the plan have a binding arbitration clause?	No	

- (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" 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) 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 may be noted in boxes 8 through 31.
- (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 may be noted in boxes 8 through 31.
- (4) Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
- (5) Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
- (6) Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.
- (7) "Emergency care" means services delivered by 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. If emergency departments are used by the plan for nonemergency after-hours care, then urgent care copayments apply.
- (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.

**Selected Benefit Descriptions**  
**Colorado Health Plan Description Form Addendum**

Humana Insurance Company

Individual Health Plan

Benefit	Benefit Level	
	In-Network	Out-of Network
4. Annual deductible (2) a. Individual b. Family	\$500/\$1,000/\$2,500/\$5,000 \$500/\$3,000/\$5,000/\$10,000	\$1,000/\$2,000/\$5,000/\$10,000 \$1,000/\$2,000/\$5,000/\$10,000
5. Out-of-pocket annual maximum (3) a. Individual b. Family c. Does not include deductible or copayments	\$2,000 Must be satisfied by each individual covered person	\$8,000 Must be satisfied by each individual covered person
6. Lifetime benefit maximum paid by the plan for all care	\$5,000,000 per covered person <i>(combined in and out of network)</i>	
11. Prescription drugs (6) a. Annual deductible <i>(separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)</i> b. Each prescription or refill <i>(up to 30-day supply)</i> : - Level One - Level Two - Level Three - Level Four  Mail order <i>(90-day supply)</i>	\$500 per individual  <b>0%</b> after: \$10 copayment after deductible \$30 copayment after deductible \$50 copayment after deductible <b>25%</b> copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year  Three times the retail copayment	\$500 per individual  <b>30%</b> after: \$10 copayment after deductible \$30 copayment after deductible \$50 copayment after deductible <b>25%</b> copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year  Three times the retail copayment
19. Other mental health care a. Inpatient <i>(up to \$2,500 maximum per calendar year for all mental health benefits)</i> b. Outpatient therapy <i>(up to \$500 maximum per calendar year for all mental health benefits. Outpatient Mental Health maximum reduces Inpatient Mental Health maximum)</i>	<b>50%</b> after deductible  <b>50%</b> after deductible	<b>50%</b> after deductible  <b>50%</b> after deductible

Benefit	Benefit Level	
	In-Network	Out-of Network
20. Alcohol and substance abuse a. Inpatient ( <i>up to \$2,500 maximum per calendar year for all mental health benefits</i> )  b. Outpatient therapy ( <i>up to \$500 maximum per calendar year for all mental health benefits</i> )	See #19, Other mental health care  See #19, Other mental health care	See #19, Other mental health care  See #19, Other mental health care
22. Durable medical equipment ( <i>preauthorization required</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
28. Dental care ( <i>for injury and for outpatient hospital and anesthesia for a covered dependent</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible
29. Vision care	No coverage	No coverage
30. Chiropractic care ( <i>see #21 for visit limitation</i> )	<b>20%</b> after deductible	<b>40%</b> after deductible