

Colorado Health Plan Description Form Humana Insurance Company Individual High Deductible 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	Plan is available throughout Colorado

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Guidance when you need it most

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 options reflect the amount the covered person will pay

Autograph Total/HSA

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type (2)	Calendar Year	Calendar Year
4A. Annual deductible (2a) a. Single (2b) b. Non-Single (aggregate) (2c)		
5. Out-of-pocket annual maximum (3) a. Individual b. Family c. Does not include deductible	\$0 \$0	\$6,000 \$12,000
6. Lifetime benefit maximum paid by the plan for all care		
7A. Covered providers	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
8. Medical office visits (4) a. Primary Care Providers b. Specialists	0% after deductible 0% after deductible	30% after deductible 30% 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</i>) (<i>up to a combined maximum of \$300 per person per calendar year</i>) 3. Annual routine Pap smear, annual routine physical exam (<i>age 13 and older</i>) (<i>up to a combined maximum of \$300 per person per calendar year</i>) 4. Routine mammogram	0% no deductible 0% no deductible 0% no deductible 0% no deductible	30% no deductible 30% no deductible No coverage No coverage 30% no deductible

Autograph Total/HSA (continued)

	IN-NETWORK	OUT-OF-NETWORK
5. Routine lab, pathology and X-ray <i>(up to a combined maximum of \$300 per person per calendar year)</i>	0% after deductible	No coverage
10. Maternity a. Prenatal care b. Delivery c. Inpatient well-baby care (5)	No coverage No coverage 0% after deductible	No coverage No coverage 30% after deductible
11. Prescription drugs (6) a. Prescription drugs used for the treatment of diabetes b. All other prescription drugs	0% after deductible Discount card included. This added value feature is not insurance.	30% after deductible No coverage
12. Inpatient Hospital	0% after deductible	30% after deductible
13. Outpatient Hospital/Ambulatory surgery	0% after deductible	30% after deductible
14. Diagnostics a. Laboratory and x-ray b. MRI, nuclear medicine and other high-tech services	0% after deductible 0% after deductible	30% after deductible 30% after deductible
15. Emergency room (7), (8)	0% after deductible	30% after deductible
16. Ambulance <i>(up to \$15,000 maximum per calendar year)</i>	0% after deductible	0% after deductible
17. Urgent, nonroutine after hours care	0% after deductible	30% after deductible
18. Biologically based mental illness (9)	No coverage	No coverage
19. Other mental health care a. Inpatient care b. Outpatient care	No coverage No coverage	No coverage No coverage
20. Alcohol and substance abuse	No coverage	No coverage
21. Physical, occupational and speech therapy <i>(limited to a combined maximum of 20 visits per calendar year)</i>	0% after deductible	30% after deductible
22. Durable medical equipment <i>(preauthorization required)</i>	0% after deductible	30% after deductible
23. Oxygen <i>(preauthorization required)</i>	0% after deductible	30% after deductible
24. Organ transplants <i>(preauthorization required)</i>	0% after deductible <i>(when services are at a National Transplant Network Provider)</i>	30% after deductible <i>(limited to \$35,000 per covered transplant)</i>
25. Home health care <i>(preauthorization required; limited to 60 visits per calendar year)</i>	0% after deductible	30% after deductible

Autograph Total/HSA (continued)

	IN-NETWORK	OUT-OF-NETWORK
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>)	0% after deductible	30% after deductible
27. Skilled nursing facility care (<i>preauthorization required; up to 30 days per calendar year</i>)	0% after deductible	30% after deductible
28. Dental care (<i>for injury and for outpatient hospital and anesthesia for a covered dependent</i>)	0% after deductible	30% after deductible
29. Vision care	No coverage	No coverage
30. Chiropractic care (<i>manipulations, adjustments, modalities</i>)	No coverage	No coverage
31. Significant additional covered services a. Care 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. e. Optional Supplemental Accident Benefit (Treatment must be provided within 90 days of the injury)	0% after deductible 0% no deductible	30% after deductible 30% no 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

	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 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 this 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 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, 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 non-preferred.
- (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) Non-emergency 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 non-emergency 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.