



Colorado Health Plan Description Form Humana Insurance Company Individual Health Plan

PART A: TYPE OF COVERAGE

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|--|--|
| 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 |

Humana Insurance Company
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Englewood, CO 80111-2926
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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

Portrait Share 80 Plus Rx and Unlimited Office Visit Copay

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--|--|
| 4. Deductible Type (2) | Calendar Year | Calendar Year |
| 4A. Annual deductible (2a) a. Individual (2b) b. Family (2c) Two family members must meet their individual deductible | Deductible Carryover – Covered expenses incurred in the last three months of the calendar year and applied to the deductible will be credited to the next calendar year deductible. | |
| 5. Out-of-pocket annual maximum (3) a. Individual b. Family c. Does not include deductible or copayments | \$2,000 \$4,000 | \$8,000 \$16,000 |
| 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 | 100% after \$35 copayment <i>(Copayments do not apply to the deductible or out-of-pocket maximum.)</i> Primary care providers include family practitioner, general practitioner, gynecologist, pediatrician or internist; Please contact Customer Service for details. 100% after \$50 copayment <i>(Copayments do not apply to the deductible or out-of-pocket maximum.)</i> Specialist contains any other participating physician. Please contact Customer Service for details. | 40% after deductible 40% after deductible |

Portrait Share 80 Plus Rx and Unlimited Office Visit Copay *(continued)*

| | IN-NETWORK | OUT-OF-NETWORK |
|---|--|---|
| <p>9. Preventive care</p> <p>a. Children's services including exams and immunizations <i>(birth to age 13)</i></p> <p>b. Adult services</p> <p>1. Annual routine PSA and digital rectal exam</p> <p>2. Routine immunizations <i>(age 13 to 18) (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)</i></p> <p>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></p> <p>4. Routine mammogram</p> <p>5. Routine lab, pathology and X-ray <i>(up to a combined maximum of \$300 per person per calendar year subject to coinsurance)</i></p> | <p>20% no deductible</p> <p>20% no deductible</p> <p>20% no deductible</p> <p>20% no deductible</p> <p>20% after deductible</p> | <p>40% no deductible</p> <p>40% no deductible</p> <p>No coverage</p> <p>No coverage</p> <p>40% no deductible</p> <p>No coverage</p> |
| <p>10. Maternity</p> <p>a. Prenatal care</p> <p>b. Delivery</p> <p>c. Inpatient well-baby care (5)</p> | <p>20% after deductible</p> | <p>40% after deductible</p> |
| <p>11. Prescription drugs (6)</p> <p>a. Annual deductible <i>(separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)</i></p> <p>b. Each prescription or refill <i>(up to 30-day supply)</i>:</p> <p>- Level One</p> <p>- Level Two</p> <p>- Level Three</p> <p>- Level Four</p> <p>Mail order <i>(90-day supply)</i></p> | <p>0% after:</p> <p>\$15 copayment</p> <p>\$35 copayment after prescription drug deductible</p> <p>\$55 copayment after prescription drug deductible</p> <p>25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year</p> <p>Three times the retail copayment</p> | <p>30% after:</p> <p>\$15 copayment</p> <p>\$35 copayment after prescription drug deductible</p> <p>\$55 copayment after prescription drug deductible</p> <p>25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year</p> <p>Three times the retail copayment</p> |
| <p>12. Inpatient hospital</p> | <p>20% after deductible</p> | <p>40% after deductible</p> |
| <p>13. Outpatient hospital/Ambulatory surgery</p> | <p>20% after deductible</p> | <p>40% after deductible</p> |

Portrait Share 80 Plus Rx and Unlimited Office Visit Copay *(continued)*

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--|--|
| 14. Diagnostics a. Laboratory and X-ray | 100% up to \$200 per calendar year, then 20% after deductible <i>(Does not apply to preventive/ routine care. This benefit does not cover MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies.)</i> | 40% after deductible |
| b. MRI, nuclear medicine and other high-tech services | 20% after deductible | 40% after deductible |
| 15. Emergency room <i>(including physician visits) (7), (8)</i> | 20% after \$75 copayment per visit and deductible <i>(copayment waived if admitted)</i> | 40% 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> | 20% after deductible | 20% after deductible |
| 17. Urgent, nonroutine after hours care | 20% after deductible | 40% after deductible |
| 18. Biologically based mental illness (9) | See #19, Other mental health care | See #19, Other mental health care |
| 19. Other mental health care a. Inpatient care <i>(up to \$2,500 combined inpatient and outpatient care maximum per calendar year for all mental health, alcohol and substance abuse benefits)</i> | 50% after deductible | 50% after deductible |
| b. Outpatient care <i>(not to exceed \$500 of the \$2,500 inpatient and outpatient care combined maximum per calendar year for all mental health, alcohol and substance abuse benefits.)</i> | 50% after deductible | 50% after deductible |
| 20. Alcohol and substance abuse a. Inpatient care <i>(up to \$2,500 combined inpatient and outpatient care maximum per calendar year for all mental health, alcohol and substance abuse benefits)</i> | See #19, Other mental health care | See #19, Other mental health care |
| b. Outpatient care <i>(not to exceed \$500 of the \$2,500 inpatient and outpatient care combined maximum per calendar year for all mental health, alcohol and substance abuse benefits.)</i> | 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> | 20% after deductible | 40% after deductible |
| 22. Durable medical equipment <i>(preauthorization required)</i> | 20% after deductible | 40% after deductible |
| 23. Oxygen <i>(preauthorization required)</i> | 20% after deductible | 40% after deductible |

Portrait Share 80 Plus Rx and Unlimited Office Visit Copay *(continued)*

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--|---|
| 24. Organ transplants (preauthorization required) | 20% after deductible <i>(when services are at a National Transplant Network Provider)</i> | 40% 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> | 20% after deductible | 40% 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> | 20% after deductible | 40% after deductible |
| 27. Skilled nursing facility care <i>(preauthorization required; up to 30 days per calendar year)</i> | 20% after deductible | 40% after deductible |
| 28. Dental care <i>(for injury and for outpatient hospital and anesthesia for a covered dependent)</i> | 20% after deductible | 40% after deductible |
| 29. Vision care | No coverage | No coverage |
| 30. Chiropractic care <i>(see #21 for visit limitation)</i> | 20% after deductible | 40% after deductible |
| 31. Significant additional covered services a. Cure and treatment of cleft lift 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 <i>(Treatment must be provided within 90 days of the injury)</i> | 20% after deductible 20% no deductible | 40% after deductible 40% 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 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 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 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. 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.