Colorado
Health Benefit Description Form

HUMANA *one*

Humana Insurance Company
Name of Carrier

Humana*One* 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	**Plan is available throughout Colorado**

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

		In-Network	Out-of-Network
4.	Deductible Type (2)	Calendar Year	Calendar Year
4A.	Annual deductible (2a)		
	a. Individual (2b)	$3,500, $4,250(12), $5,000, $6,000(12)	$7,000, $8,500, $10,000, $12,000
	b. Family (2c)	$10,500, $12,750, $15,000, $18,000	$21,000, $25,500, $30,000, $36,000
		Three family members must meet their individual deductible	
5.	Out-of-pocket annual maximum (3)		
	a. Individual	$3,500	$12,000
	b. Family	$7,000	$24,000
	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
8.	Medical office visits (4)		
	a. Primary care providers 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 Limited to 6 combined (PCP & Specialist) visits per calendar year per person, After 6 visits met, then 20% after deductible; (Copayments do not apply to the deductible or out-of-pocket maximum.)	40% after deductible

	In-Network	Out-of-Network
b. Specialists Specialist contains any other participating physician. Please contact Customer Service for details.	0% after $60 copayment Limited to 6 combined (PCP & Specialist) visits per calendar year per person, After 6 visits met, then 20% after deductible; (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. Preventive 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, limited to 6 combined (PCP & Specialist) visits per calendar year per person. After 6 visits met, then 20% after deductible; (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
11. Prescriptions drugs (6)		
a. Annual deductible (separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)	$700 prescription drug deductible per individual $300 prescription drug deductible per individual	

	In-Network	Out-of-Network
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 $400 per calendar year paid at 100% per person, then 20% after deductible The first $400 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 (access fee waived if admitted)	20% after $100 access fee per visit and deductible (access fee waived if admitted)
16. Ambulance	20% after deductible	20% after deductible
17. Urgent, non routine after hours care	0% after $60 copayment Limited to 6 combined (PCP & Specialist) visits per calendar year per person, after 6 visits met, then 20% after deductible; (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)	Option not selected First $1,000 per accident at 0%, then base plan benefits apply First $2,500 per accident at 0%, then base plan benefits apply	

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-existion condition limitation does not apply to a covered person who is under the age of 19.
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 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 P.O. Box 14616 Lexington, KY 40512-4616 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 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-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 an 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.

(12) Only available at renewal.

Insured by 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

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.