

Colorado

HumanaOne Annual Max plans: Coverage at an affordable price

If you're looking for health insurance that offers both an affordable premium and a low annual deductible and do not feel you need coverage for major expenses that could exceed \$100,000 or \$250,000, then an Annual Max plan from HumanaOne may be a smart choice for you.

Choose from a variety of deductibles and plan options to create a plan that meets your needs and fits your budget. With HumanaOne's Annual Max Plans you can have affordable coverage that helps protect you and your family.

Here's how it works:

Annual Max plans have calendar year dollar limits, or caps, that keep premiums affordable and deductibles low. When you select your Annual Max plan, it's important to remember that you are responsible for expenses that exceed these calendar year dollar limits. Create an Annual Max plan that's right for you:

- 1 Choose your deductible.** Annual Max plans offer a range of deductibles; you can decide which option works best for you.
- 2 Select your annual maximum amount.** This is the total amount your plan will pay for covered services each calendar year. You can select an annual maximum of \$100,000 or \$250,000.
- 3 Know your outpatient services annual maximum.** The total amount your plan pays for outpatient services is \$5,000 each calendar year. If you select the \$250,000 annual maximum option, you have the option to increase this limit to \$10,000.

Important information about annual maximums:

- › Each person on the policy has their own annual maximums.
- › Annual maximums reset every January.
- › You are entirely responsible for any charges that exceed your annual maximums.
- › Expenses applied toward the outpatient services will also be applied to, and reduce, your annual maximum amount.
- › Annual maximums are unique to this plan; HumanaOne offers other plans without an annual maximum.

The HumanaOne 75/55 Annual Max plan offers:

- › **Prescription drug coverage:** After meeting your prescription deductible and paying applicable copayments, this plan pays 100 percent for all prescriptions up to \$2,500 per calendar year.
- › **Preventive care and physician services benefits:** All Annual Max plans include coverage for in-network preventive care, including office visits, child immunizations and preventive lab and X-ray. You're also covered for other important services, such as office visits for illness and injury and emergency services.
- › **Network savings:** With Annual Max plans, you have access to a large network of doctors, whether you are at home or traveling. You'll receive the most savings when visiting network providers, but you're still covered for most services if you choose to visit a non-network provider.
- › **Service you can rely on:** Service is our top priority. We give you guidance and support, and we make it easy for you to work with us from the start.

Colorado Annual Max 75/55 plan

		Plan pays for services from NETWORK providers ⁸	Plan pays for services from NON-NETWORK providers ⁹								
Deductible options¹ • per calendar year • copayments do not apply	<ul style="list-style-type: none"> individual family (three family members must each meet their individual deductible) 	\$1,000, \$2,000 or \$3,000 \$3,000, \$6,000 or \$9,000	\$2,000, \$4,000 or \$6,000 \$6,000, \$12,000 or \$18,000								
Annual maximum options • per calendar year • all covered services apply		\$100,000 or \$250,000 paid by plan per covered person									
Outpatient services maximum options • per calendar year • reduces annual maximum		\$5,000 paid by plan for \$100,000 annual maximum \$5,000 or \$10,000 paid by plan for \$250,000 annual maximum									
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copays do not apply	<ul style="list-style-type: none"> individual family 	\$3,500 \$7,000	\$10,000 \$20,000								
Preventive care	<ul style="list-style-type: none"> well-child care (including immunizations) (birth to age 13) prostate screening and digital rectal exam mammogram preventive office visits (age 13 and older)² routine immunizations (age 13 to age 18)² Pap smears² preventive lab and X-ray² 	75% 75% 75% after deductible	55% Not covered Not covered								
Physician services	<ul style="list-style-type: none"> office visits for illness or injury (including allergy injections) diagnostic lab and X-ray³ allergy testing allergy serum inpatient and outpatient services surgery emergency services 	Deductible \$1,000 or \$2,000 \$3,000 \$1,000 or \$2,000 \$3,000 \$1,000, \$2,000 and \$3,000	100% after office visit copay of \$35 for primary care and \$50 for specialty care up to 3 combined visits, then 75% after deductible 75% after deductible First \$100 per calendar year 100% then 75% after deductible ⁴ 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% after deductible							
Facility services	<ul style="list-style-type: none"> inpatient and outpatient services outpatient surgery emergency services (copayment waived if admitted) 	75% after deductible 75% after \$125 copay per visit and deductible	55% after deductible 55% after \$125 copay per visit and deductible								
Rx4 prescription drug⁵	<ul style="list-style-type: none"> benefit maximum (per covered person per calendar year) deductible per covered person copay for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply) benefit per prescription or refill mail order (up to 90-day supply) 		\$2,500 paid by plan Separate \$500 deductible* <table border="1"> <thead> <tr> <th>Level 1</th> <th>Level 2</th> <th>Level 3</th> <th>Level 4</th> </tr> </thead> <tbody> <tr> <td>\$15*</td> <td>\$40</td> <td>\$65</td> <td>25%</td> </tr> </tbody> </table> *Level 1 drugs subject to copay, no deductible 100% after prescription copay 70% after prescription copay 100% after three times retail copay 70% after three times retail copay	Level 1	Level 2	Level 3	Level 4	\$15*	\$40	\$65	25%
Level 1	Level 2	Level 3	Level 4								
\$15*	\$40	\$65	25%								
Other medical services • prior authorization required in order to be eligible for these benefits	<ul style="list-style-type: none"> skilled nursing facility (up to 30 days per calendar year) hospice⁶ home health care (up to 60 visits per calendar year) durable medical equipment pregnancy complications and sick baby services⁷ (no prior authorization required) transplant services 	75% after deductible 75% after deductible when services are received from a Humana Transplant Network provider	55% after deductible 55% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant								
Lifetime maximum benefit		\$2,000,000 per covered person									
Behavioral health (mental health, chemical and alcohol dependency)	<ul style="list-style-type: none"> inpatient services outpatient and office therapy sessions 	Not covered	Not covered								
Optional benefits • these are available to add for an additional cost	<ul style="list-style-type: none"> supplemental accident benefit (\$500 or \$1,000) (treatment must be provided within 90 days of the injury) 	First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply									

Colorado Annual Max 75/55 plan

To be covered, expenses must be medically necessary and specified as covered. Please see your policy for more information on medical necessity and other specific plan benefits.

- When you obtain care from non-network providers:
 - your payment toward the deductible is **NOT** credited to the deductible for network providers
 - your out-of-pocket costs are **NOT** credited to the out-of-pocket maximum for network providers
- Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
- MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
- This is a combined maximum to include diagnostic lab/x-ray/interpretation, in a clinic or outpatient location.
- If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement. The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.
- 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.
- This benefit also covers well-baby charges for a hospital stay of 48 hours following a vaginal delivery and 96 hours following a Cesarean section. If delivery occurs after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.
- The Preferred Provider Organization (PPO) Network has an inadequate number of providers in the following counties in Colorado: Dolores, Gunnison, Hinsdale, Mineral, Ouray, Saguache, San Juan, San Miguel.**
- Non-network providers may balance bill you for the difference between the amount paid by us and the non-network providers billed charges if:**
 - You are required to travel no more than a reasonable distance beyond the plan's service area in order to receive services from a network provider**
 - The covered person knowingly seeks services from a non-network provider; and**
 - The non-network provider is reimbursed for an amount less than the billed charge**

Payments

Network providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to non-network providers are based on maximum allowable fees, as defined in your policy.

Non-network providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Network primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Medical limitations and exclusions

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

Eligibility

The issue ages for HumanaOne individual health plans are two months to 64.5 years. The maximum age for a dependent child is 25 years provided the child is financially dependent on and resides with the policyholder.

Pre-existing conditions

A pre-existing condition is a sickness, injury or pregnancy for which a covered person incurs charges, receives medical treatment, consulted with a healthcare practitioner or took prescription drugs within the 12-month period before their effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Other expenses not covered

Unless stated otherwise no benefits are payable for expenses arising from:

- Services not medically necessary or which are experimental, investigational or for research purposes.
- Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
- Services while confined in a hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the covered person's home or who is a family member, or that are performed in association with a services that is not covered under the policy.
- Charges in excess of the maximum allowable fee or which exceed any benefit maximum, calendar year policy maximum or lifetime maximum.
- Services provided by a Chiropractor, including but not limited to exams, x-rays, laboratory, spinal manipulations and spinal adjustment modalities.
- Expenses incurred before the effective date or after the date coverage is terminated.
- Cosmetic procedures and any related complications except as stated in the policy.
- Custodial or maintenance care.
- Any drug, medicine or device which is not FDA approved.
- Contraceptives, including oral and transdermal, whether medication or device.
- Medications, drugs or hormones to stimulate growth.
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered bodily injury or sickness.
- Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature; experimental or investigational use drugs.
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
- Drugs used in treatment of nail fungus.
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than 1 year from the date of the original order.
- Vitamins, dietary products and any other non-prescription supplements.
- Infertility services.
- Pregnancy and well-baby expenses, except as stated in the policy.
- Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
- Vision therapy; all types of refractive keratoplastics or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses, hearing aids; dental exams.
- Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
- Services received at an emergency room unless required because of emergency care.

continued >

Medical limitations and exclusions (continued)

24. Dental services (except for dental injury), appliances or supplies, except as stated in the policy.
25. War or any act of war, whether declared or not, commission or attempt to commit a civil or criminal battery or felony.
26. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation except as stated in the policy.
27. Any treatment for the purpose of reducing obesity or any use of obesity reduction procedures to treat sickness or bodily injury caused by complicated by or exacerbated by obesity, including but not limited to surgical procedures.
28. Nicotine habit or addiction; educational or vocational therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services, sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
29. Foot care services.
30. Any treatment for mental health, including but not limited to prescription drugs.
31. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
32. Health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs, personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
33. Hair prosthesis; hair transplants or wigs.
34. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
35. Bodily injury and sickness arising out of the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a covered person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the covered person is not covered under a Workers' Compensation plan, except for certain professions or activities as stated in the policy.
36. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
37. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
38. Charges covered by other medical payments insurance.
39. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
40. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.

Important information about Annual Max plans:

This HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses applied to the outpatient and pharmacy calendar year limits will also be applied to the all covered services calendar year limit. Any costs incurred for services above the calendar year limits are the member's responsibility. Humana has other plans available that do not have calendar year limits, see your state-specific benefit summary for details.

Colorado law required carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. 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 plan of the carrier.

A copy of the Colorado Network Access plan can be provided upon request.



Insured by Humana Insurance Company

Applications are subject to approval. Waiting periods, limitations and exclusions apply.
The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

Individual Dental Insurance

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of the more than 110,000 dentist locations in the PPO network. You can find a dentist by visiting Humana.com. This is not a complete disclosure of plan qualifications and limitations. Please review the specific Dental Limitations & Exclusions before applying for coverage.

		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Preventive services	<ul style="list-style-type: none"> oral examinations routine cleanings x-rays sealants topical fluoride treatment 	100% no deductible	100% no deductible
Basic services	<ul style="list-style-type: none"> emergency care for pain relief thumb sucking and harmful habit appliances space maintainers amalgam, composite fillings (front/anterior teeth only) oral surgery routine extractions non-cast stainless steel crowns partial or complete denture repairs/adjustments 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 			
Major services	<ul style="list-style-type: none"> endodontics (root canals) periodontics crowns inlays and onlays partial or complete dentures denture relines/rebases removable or fixed bridgework 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> twelve month waiting period applies 			
Teeth whitening	<ul style="list-style-type: none"> \$200 lifetime maximum 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 			
Orthodontia	<ul style="list-style-type: none"> Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount. 		
Annual deductible		\$50 individual / \$150 family	
Annual maximum		\$1,000	

Individual Term Life Insurance

With HumanaOne term life, you can buy a higher amount of insurance protection at a lower cost. You own the policy and maintain control, providing more flexibility for your family.

Coverage amounts	<ul style="list-style-type: none"> Amounts start at \$25,000 and can go up to a maximum of \$150,000
Term levels	<ul style="list-style-type: none"> Ages 18-65 for a 10-year level premium term Ages 18-60 for a 15-year level premium term Ages 18-55 for a 20-year level premium term
Rate guarantee	<ul style="list-style-type: none"> Rates are guaranteed for the full term of the policy
Renewals	<ul style="list-style-type: none"> HumanaOne Term Life Insurance is guaranteed renewable to age 95. Premiums after the initial level premium period will increase annually, but are also guaranteed.

Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the HumanaOne Individual Dental Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

Unless stated otherwise, no benefits are payable for expenses arising from:

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government, unless legally required to pay.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.



Insured by Humana Insurance Company or HumanaDental Insurance Company or The Dental Concern, Inc.

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