

Humana Insurance Company  
Name of Carrier

**Colorado Standard PPO**  
Name of Plan

**Part A: Type of Coverage**

1. TYPE OF PLAN	Preferred Provider Organization																																																					
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Yes, but patient pays more for out-of-network care																																																					
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	<b>Plan is available only in the following areas (counties):</b> For the Advantage Network: Boulder, El Paso, Teller																																																					
	For the ChoiceCare Network:  <table border="0"> <tr> <td>Adams</td> <td>Clear Creek</td> <td>El Paso</td> <td>La Plata</td> <td>Montrose</td> <td>Routt</td> </tr> <tr> <td>Alamosa</td> <td>Conejos</td> <td>Elbert</td> <td>Lake</td> <td>Morgan</td> <td>Sedgwick</td> </tr> <tr> <td>Arapahoe</td> <td>Costilla</td> <td>Fremont</td> <td>Larimer</td> <td>Otero</td> <td>Summit</td> </tr> <tr> <td>Baca</td> <td>Crowley</td> <td>Garfield</td> <td>Las Animas</td> <td>Park</td> <td>Teller</td> </tr> <tr> <td>Bent</td> <td>Custer</td> <td>Huerfano</td> <td>Lincoln</td> <td>Phillips</td> <td>Washington</td> </tr> <tr> <td>Boulder</td> <td>Delta</td> <td>Jackson</td> <td>Logan</td> <td>Pitkin</td> <td>Weld</td> </tr> <tr> <td>Broomfield</td> <td>Denver</td> <td>Jefferson</td> <td>Mesa</td> <td>Prowers</td> <td>Yuma</td> </tr> <tr> <td>Chaffee</td> <td>Douglas</td> <td>Kiowa</td> <td>Moffat</td> <td>Pueblo</td> <td></td> </tr> <tr> <td>Cheyenne</td> <td>Eagle</td> <td>Kit Carson</td> <td>Montezuma</td> <td>Rio Grande</td> <td></td> </tr> </table>	Adams	Clear Creek	El Paso	La Plata	Montrose	Routt	Alamosa	Conejos	Elbert	Lake	Morgan	Sedgwick	Arapahoe	Costilla	Fremont	Larimer	Otero	Summit	Baca	Crowley	Garfield	Las Animas	Park	Teller	Bent	Custer	Huerfano	Lincoln	Phillips	Washington	Boulder	Delta	Jackson	Logan	Pitkin	Weld	Broomfield	Denver	Jefferson	Mesa	Prowers	Yuma	Chaffee	Douglas	Kiowa	Moffat	Pueblo		Cheyenne	Eagle	Kit Carson	Montezuma	Rio Grande
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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 options reflect the amount the insured will pay.

	In-Network	Out-of-Network
4. ANNUAL DEDUCTIBLE <sup>2</sup>	Deductibles per calendar year (in- and out-of-network deductible accumulate separately)	Deductibles per calendar year (in- and out-of-network deductible accumulate separately)
a. Individual	\$1,500	\$3,000
b. Family	\$4,500	\$9,000
5. ENROLLEE OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup>	Out-of-pocket per calendar year (includes deductible, excludes copayments) (In-network out-of-pockets are separate from out-of-network out-of-pocket)	Out-of-pocket per calendar year (includes deductible, excludes copayments) (In-network out-of-pockets are separate from out-of-network out-of-pocket)
a. Individual	\$3,500	\$7,000
b. Family	\$7,000	\$14,000
c. Is deductible included in the out-of-pocket maximum?	yes	yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$5,000,000 (combined in- and out-of-network)	

	In-Network	Out-of-Network
7A. COVERED PROVIDERS	ChoiceCare network. See applicable 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?	Yes	Not applicable
8. MEDICAL OFFICE VISITS <sup>4</sup>	0% after office visit copayment	50% to coinsurance limit after deductible
9. PREVENTIVE CARE		
a. Children's services	0% after \$25 copayment per visit	50% to coinsurance limit (no deductible)
b. Adults' services	0% after \$25 copayment per visit	50% to coinsurance limit
9. PREVENTIVE CARE		
All Persons	<ul style="list-style-type: none"> <li>One smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed \$150 payment by insurer.</li> <li>Chicken pox vaccination for all persons who have not had chicken pox.</li> </ul>	
Females	<ul style="list-style-type: none"> <li>Full cost of cervical cancer vaccine.</li> </ul>	
All Children	<ul style="list-style-type: none"> <li>Routine immunizations recommended by the ACIP/AAP/AAFP.</li> <li>Immunization deficient children are not bound by "recommended ages" on ACIP/ AAP/AAFP chart.</li> </ul>	
Age 0-12 months	<ul style="list-style-type: none"> <li>One newborn home visit during first week of life if newborn is released from hospital less than 48 hours after delivery.</li> <li>5 well child visits (excludes lab and x-ray)</li> <li>One PKU</li> </ul>	
Age 13-35 months	<ul style="list-style-type: none"> <li>Two well child visits (excludes lab and x-ray)</li> </ul>	
Age 3-6	<ul style="list-style-type: none"> <li>Three well child visits (excludes lab and x-ray)</li> </ul>	
Age 7-12	<ul style="list-style-type: none"> <li>Three well child visits (excludes lab and x-ray)</li> </ul>	
Age 13-18	<ul style="list-style-type: none"> <li>One age appropriate health maintenance visit every year (excludes lab and x-ray)</li> <li>One TD</li> <li>Females: screening pap smears not to exceed one per year</li> <li>One hepatitis B vaccination if not given previously</li> </ul>	
Age 19-39	<ul style="list-style-type: none"> <li>One TD every ten years</li> <li>One age appropriate health maintenance visit every three years (exclude lab and x-ray)</li> <li>One fasting lipid panel every five years</li> <li>Females: screening pap smears not to exceed one per year</li> <li>Females ages 35-39: one baseline screening mammogram and clinical breast exam</li> </ul>	
Age 40-64	<ul style="list-style-type: none"> <li>One TD every ten years</li> <li>One fasting lipid panel every five years</li> <li>Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> <li>One age appropriate health maintenance visit every 24 months (excludes lab and x-ray)</li> <li>Females: screening pap smears not to exceed one per year</li> <li>Females ages 40-49: one screening mammogram and clinical breast exam every two years (annually if high risk)</li> <li>Females ages 50-64: one screening mammogram and clinical breast exam every 12 months</li> <li>Males: prostate screening as specified in state law</li> </ul>	
Age 65 and older	<ul style="list-style-type: none"> <li>One influenza immunization every year</li> <li>One pneumococcal vaccine at or after age 65</li> <li>Females: screening pap smears not to exceed one per year</li> <li>One TD every ten years</li> <li>One age appropriate health maintenance visit per year (excludes lab and x-ray)</li> <li>Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> <li>Females age 65-74: one screening mammogram and clinical breast exam every 12 months</li> </ul>	

	In-Network	Out-of-Network
10. MATERNITY		
a. Prenatal	20% to coinsurance limit (a one time \$25 copayment for all routine prenatal visits combined, then deductible and coinsurance for all other charges)	50% to coinsurance limit
b. Delivery and inpatient well baby care <sup>5</sup>	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions <sup>6</sup>	30-day supply (includes contraceptives) \$10/\$40/\$60	30-day supply (includes contraceptives) \$10/\$40/\$60
12. INPATIENT HOSPITAL	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible
13. OUTPATIENT/AMBULATORY SURGERY	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible
14. DIAGNOSTICS a. Laboratory and X-ray b. MRI, nuclear medicine, CT, CTA, MRA, and PET scans	20% to coinsurance limit after deductible (diagnostic only) (not performed in clinic) If these services are delivered in conjunction with an office visit where a copayment is charged, no additional copayment or coinsurance requirement for lab & x-ray services is applied.	50% to coinsurance limit after deductible (diagnostic only) (not performed in clinic)
15. EMERGENCY CARE <sup>7,8</sup>	20% after \$150 copayment, and to coinsurance limit	20% after \$125 copayment, and to coinsurance limit
16. AMBULANCE	20% to coinsurance limit after deductible	20% to coinsurance limit after in-network deductible
17. URGENT, NON-ROUTINE AFTER HOURS CARE	\$75 copayment per visit	50% to coinsurance limit after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>9</sup>	Coverage is no less extensive than the coverage provided for any other physical illness. All other mental illnesses (see footnote #4) under the certificate of Insurance are non-biologically based.	Coverage is no less extensive than the coverage provided for any other physical illness. All other mental illnesses (see footnote #4) under the certificate of Insurance are non-biologically based.
19. OTHER MENTAL HEALTH CARE	Non-biologically based mental illness	Non-biologically based mental illness
a. Inpatient care	50% to coinsurance limit after deductible. (Maximum 45 inpatient or 90 days of residential or partial hospitalization per calendar year in- and out-of-network combined).	50% to coinsurance limit after deductible. (Maximum 45 inpatient or 90 days of residential or partial hospitalization per calendar year in- and out-of-network combined).
b. Outpatient care	50% to coinsurance limit after deductible (Covered services payable to \$1,500 per calendar year in and out of network combined).	50% to coinsurance limit after deductible (Covered services payable to \$1,500 per calendar year in and out of network combined).
20A. ALCOHOL ABUSE	Inpatient: 50% to coinsurance limit after deductible (maximum of 45 days inpatient per calendar year in- and out-of-network combined). (including detox treatment)  Outpatient: 50% to coinsurance limit after deductible (limited up to \$500 per calendar year in- and out-of-network combined).	Inpatient: 50% to coinsurance limit after deductible (maximum of 45 days inpatient per calendar year in- and out-of-network combined). (including detox treatment)  Outpatient: 50% to coinsurance limit after deductible (limited up to \$500 per calendar year in- and out-of-network combined).
20B. ALCOHOL AND SUBSTANCE ABUSE	50% to coinsurance limit after deductible (Acute detoxification only-five days per episode; two episodes per lifetime in and out-of-network combined)	50% to coinsurance limit after deductible (Acute Detoxification only-5 days per episode; two episodes per lifetime in and out-of-network combined)
21. OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	20% to coinsurance limit after deductible (limited to 25 visits per therapy per year)	50% to coinsurance limit after deductible

	In-Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	20% to coinsurance limit after deductible  Maximum in and out of network combined benefit per calendar year of \$2,000 per covered person. See policy for types and circumstances of coverage.	50% to coinsurance limit after deductible  Maximum in and out of network combined benefit per calendar year of \$2,000 per covered person. See policy for types and circumstances of coverage.
23. OXYGEN	20% to coinsurance limit after deductible Benefit applies to and is limited by the durable medical equipment maximum of \$2,000 per calendar year.	50% to coinsurance limit after deductible Benefit applies to and is limited by the durable medical equipment maximum of \$2,000 per calendar year.
24. ORGAN TRANSPLANTS	20% to coinsurance limit after deductible  See policy for types and circumstances of coverage.	50% to coinsurance limit after deductible  See policy for types and circumstances of coverage.
25. HOME HEALTH CARE	20% to coinsurance limit after deductible (limited to 60 visits per calendar year in- and out-of-network combined).	50% to coinsurance limit after deductible (limited to 60 visits per calendar year in- and out-of-network combined).
26. HOSPICE CARE	20% to coinsurance limit after deductible (short-term crisis payable to 30-days per calendar year in and out-of-network combined)	50% to coinsurance limit after deductible (short-term crisis payable to 30-days per calendar year in and out-of-network combined)
27. SKILLED NURSING FACILITY CARE	20% to coinsurance limit after deductible  Maximum of 100 days per calendar year in and out of network combined	50% to coinsurance limit after deductible  Maximum of 100 days per calendar year in and out of network combined
28. DENTAL CARE	Available as a separate dental care plan.	Available as a separate dental care plan
29. VISION CARE	No coverage	No coverage
30. CHIROPRACTIC CARE	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible
31. SIGNIFICANT ADDITIONAL COVERED SERVICES		
a. Allergy injections and serum in the doctor's office	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible
b. Jaw Joint Disorder	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible
c. Second Opinion	20% to coinsurance limit after deductible	50% to coinsurance limit after deductible

## Part C: Limitations and Exclusions

32. Period during which pre-existing conditions are not covered. <sup>10</sup>	Business groups of One: up to 12 months for all pre-existing conditions Business groups of 2-50: up to six months for all pre-existing conditions
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. How Does The Policy Define A "Pre-existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
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 then 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 ( <i>except in an emergency</i> )?	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?	1-800-558-4444	
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Humana Insurance Company Grievance and Appeals Office P.O. Box 14610 Lexington, KY 40512-4610 1-800-558-4444	
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 # CO-57314-07 E et al group - all sizes	
43. Does this plan have a binding arbitration clause?	No	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" 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" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles 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 non-preferred.
7. "Emergency care" means services delivered by an emergency care facility that 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 condition exclusions. State law requires carriers to waive some or all of the preexisting 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.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

Insured by Humana Insurance Company

Humana Insurance Company  
Name of Carrier

**Colorado Standard Indemnity**  
Name of Plan

**Part A: Type of Coverage**

1. TYPE OF PLAN	Medical expense policy
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Yes, policy makes no distinction between in- and out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	<b>Plan is available throughout Colorado.</b>

**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 insured will pay.

Benefit Levels	
4. ANNUAL DEDUCTIBLE <sup>2</sup>	Per calendar year
a. Individual	\$2,000
b. Family	\$6,000
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup>	Per calendar year (out-of-pocket includes deductible)
a. Individual	\$4,000
b. Family	\$12,000
c. Is deductible included in the out-of-pocket maximum?	yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000
7A. COVERED 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.
8. MEDICAL OFFICE VISITS <sup>4</sup>	20% to coinsurance limit after deductible
9. PREVENTIVE CARE	
a. Children's services	20%
b. Adults' services	20% after deductible

**Benefit Levels**

<b>9. PREVENTIVE CARE</b>	
All Persons	<ul style="list-style-type: none"> <li>• One smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed \$150 payment by insurer.</li> <li>• Chicken pox vaccination for all persons who have not had chicken pox.</li> </ul>
Females	<ul style="list-style-type: none"> <li>• Full cost of cervical cancer vaccine.</li> </ul>
All Children	<ul style="list-style-type: none"> <li>• Routine immunizations recommended by the ACIP/AAP/AAFP.</li> <li>• Immunization deficient children are not bound by "recommended ages" on ACIP/ AAP/AAFP chart.</li> </ul>
Age 0-12 months	<ul style="list-style-type: none"> <li>• One newborn home visit during first week of life if newborn is released from hospital less than 48 hours after delivery.</li> <li>• 5 well child visits (excludes lab and x-ray)</li> <li>• One PKU</li> </ul>
Age 13-35 months	<ul style="list-style-type: none"> <li>• Two well child visits (excludes lab and x-ray)</li> </ul>
Age 3-6	<ul style="list-style-type: none"> <li>• Three well child visits (excludes lab and x-ray)</li> </ul>
Age 7-12	<ul style="list-style-type: none"> <li>• Three well child visits (excludes lab and x-ray)</li> </ul>
Age 13-18	<ul style="list-style-type: none"> <li>• One age appropriate health maintenance visit every year (excludes lab and x-ray)</li> <li>• One TD</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• One hepatitis B vaccination if not given previously</li> </ul>
Age 19-39	<ul style="list-style-type: none"> <li>• One TD every ten years</li> <li>• One age appropriate health maintenance visit every three years (exclude lab and x-ray)</li> <li>• One fasting lipid panel every five years</li> <li>• Females ages 35-39: one baseline screening mammogram and clinical breast exam</li> <li>• Females: screening pap smears not to exceed one per year</li> </ul>
Age 40-64	<ul style="list-style-type: none"> <li>• One TD every ten years</li> <li>• One fasting lipid panel every five years</li> <li>• Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> <li>• One age appropriate health maintenance visit every 24 months (excludes lab and x-ray)</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• Females ages 40-49: one screening mammogram and clinical breast exam every two years (annually if high risk)</li> <li>• Females ages 50-64: one screening mammogram and clinical breast exam every 12 months</li> <li>• Males: prostate screening as specified in state law</li> </ul>
Age 65 and older	<ul style="list-style-type: none"> <li>• One influenza immunization every year</li> <li>• One pneumococcal vaccine at or after age 65</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• One TD every ten years</li> <li>• One age appropriate health maintenance visit per year (excludes lab and x-ray)</li> <li>• Females age 65-74: one screening mammogram and clinical breast exam every 12 months</li> <li>• Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> </ul>
<b>10. MATERNITY</b>	
a. Prenatal care	20% to coinsurance limit (not subject to deductible)
b. Delivery and inpatient well baby care <sup>5</sup>	Coverage is no less extensive than the coverage provided for any other physical illness
<b>11. PRESCRIPTION DRUGS</b> <sup>6</sup> Level of coverage and restrictions on prescriptions	(30 day supply on new or refills) (includes contraceptives) \$10/\$40/\$60
<b>12. INPATIENT HOSPITAL</b>	20% to out-of-pocket maximum after deductible
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	20% to coinsurance limit after deductible

**Benefit Levels**

14. DIAGNOSTICS a. Laboratory and X-ray b. MRI, nuclear medicine, CT, CTA, MRA, and PET scans	20% to coinsurance limit after deductible (not performed in clinic) (diagnostic only)
15. EMERGENCY CARE <sup>7,8</sup>	20% to coinsurance limit after deductible
16. AMBULANCE	20% to coinsurance limit after deductible
17. URGENT, NON-ROUTINE AFTER HOURS CARE	20% to coinsurance limit after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>9</sup>	Coverage is no less extensive than the coverage provided for any other physical illness  All other mental illnesses (see footnote #4) under the Certificate of Insurance are non-biologically based
19. OTHER MENTAL HEALTH CARE	Non-biologically based mental illness.
a. Inpatient Care	50% to coinsurance limit after deductible. (Maximum 45 inpatient or 90 days of residential or partial hospitalization per calendar year - one day of inpatient care equals two days of partial hospitalization).
b. Outpatient Care	Outpatient and Office Therapy: 20% to coinsurance limit after deductible
20A. ALCOHOL ABUSE	Inpatient: 50% to coinsurance limit after deductible (limited to 45 days per calendar) (including detox treatment)  Outpatient and Office Therapy: 50% to coinsurance limit after deductible
20B. ALCOHOL AND SUBSTANCE ABUSE	50% to coinsurance limit after deductible (Acute Detoxification only - 5 days per episode; 2 episodes per lifetime)
21. OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	20% to coinsurance limit after deductible (limited to 25 visits per therapy per year)
22. DURABLE MEDICAL EQUIPMENT	20% to coinsurance limit after deductible (limited to \$2,000 per calendar year per covered person) See policy for types and circumstances of coverage
23. OXYGEN	20% to coinsurance limit after deductible Benefit applies to and is limited by the durable medical equipment maximum of \$2,000 per calendar year
24. ORGAN TRANSPLANTS	20% to coinsurance limit after deductible See policy for types and circumstances of coverage
25. HOME HEALTH CARE	20% to coinsurance limit after deductible (limited to 60 visits per calendar year)
26. HOSPICE CARE	20% to coinsurance limit after deductible (short-term crisis payable to 30 days per calendar year)
27. SKILLED NURSING FACILITY CARE	20% to coinsurance limit after deductible (limited to 100 days per calendar year).
28. DENTAL CARE	Available as a separate dental care plan
29. VISION CARE	No coverage
30. CHIROPRACTIC CARE	20% to coinsurance limit after deductible
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	
a. Jaw Joint Disorder	20% to coinsurance limit after deductible
b. Allergy injections and serum in the doctor's office	20% to coinsurance limit after deductible
c. Second Opinion	20% to coinsurance limit after deductible

## Part C: Limitations and Exclusions

32. Period during which pre existing conditions are not covered. <sup>10</sup>	Business groups of One: up to 12 months for all pre-existing conditions Business groups of 2-50: up to six months for all pre-existing conditions
33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. How does the policy define a "pre-existing condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
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 then to see if a service or treatment you may need is excluded from the policy.

## Part D: Using the Plan

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
37. Is prior authorization required for surgical procedures and hospital care ( <i>except in an emergency</i> )?	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
39. What is the main Customer Service number?	1-800-558-4444
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Humana Insurance Company Grievance and Appeals Office P.O. Box 14610 Lexington, KY 40512-4610 1-800-558-4444
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 # CO-57314-07 E et al group - all sizes
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" 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" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles 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 non-preferred.
7. "Emergency care" means services delivered by an emergency care facility that 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 condition exclusions. State law requires carriers to waive some or all of the preexisting 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.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

Insured by Humana Insurance Company

Humana Insurance Company  
Name of Carrier

**Colorado Standard HMO**  
Name of Plan

**Part A: Type of Coverage**

1. TYPE OF PLAN	Health maintenance organization
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	<b>Plan is available only in the following areas (counties):</b>
	HumanaHMO Select Network: Adams                      Boulder                      Denver                      Elbert                      Jefferson Arapahoe                      Broomfield                      Douglas                      El Paso                      Teller

**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 insured will pay.

Benefit Levels	
4. ANNUAL DEDUCTIBLE <sup>2</sup>	Per calendar year
a. Individual	No deductible
b. Family	No deductible
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup>	Per calendar year
a. Individual	\$3,000
b. Family	\$6,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum
7A. COVERED PROVIDERS	HumanaHMO Select Network [See provider directory for complete list of current providers.]
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. MEDICAL OFFICE VISITS <sup>4</sup>	
a. Primary care physician	\$25 copayment per visit
b. Specialist	\$40 copayment per visit
9. PREVENTIVE CARE	
a. Children’s services	\$25 copayment per visit
b. Adults’ services	\$25 copayment per visit

**Benefit Levels**

<b>9. PREVENTIVE CARE</b>	
All Persons	<ul style="list-style-type: none"> <li>• One smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed \$150 payment by insurer.</li> <li>• Chicken pox vaccination for all persons who have not had chicken pox.</li> </ul>
Females	<ul style="list-style-type: none"> <li>• Full cost of cervical cancer vaccine.</li> </ul>
All Children	<ul style="list-style-type: none"> <li>• Routine immunizations recommended by the ACIP/AAP/AAFP.</li> <li>• Immunization deficient children are not bound by “recommended ages” on ACIP/ AAP/AAFP chart.</li> </ul>
Age 0-12 months	<ul style="list-style-type: none"> <li>• One newborn home visit during first week of life if newborn is released from hospital less than 48 hours after delivery.</li> <li>• 5 well child visits (excludes lab and x-ray)</li> <li>• One PKU</li> </ul>
Age 13-35 months	<ul style="list-style-type: none"> <li>• Two well child visits (excludes lab and x-ray)</li> </ul>
Age 3-6	<ul style="list-style-type: none"> <li>• Three well child visits (excludes lab and x-ray)</li> </ul>
Age 7-12	<ul style="list-style-type: none"> <li>• Three well child visits (excludes lab and x-ray)</li> </ul>
Age 13-18	<ul style="list-style-type: none"> <li>• One age appropriate health maintenance visit every year (excludes lab and x-ray)</li> <li>• One TD</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• One hepatitis B vaccination if not given previously</li> </ul>
Age 19-39	<ul style="list-style-type: none"> <li>• One TD every ten years</li> <li>• One age appropriate health maintenance visit every three years (exclude lab and x-ray)</li> <li>• One fasting lipid panel every five years</li> <li>• Females ages 35-39: one baseline screening mammogram and clinical breast exam</li> <li>• Females: screening pap smears not to exceed one per year</li> </ul>
Age 40-64	<ul style="list-style-type: none"> <li>• One TD every ten years</li> <li>• One fasting lipid panel every five years</li> <li>• Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> <li>• One age appropriate health maintenance visit every 24 months (excludes lab and x-ray)</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• Females ages 40-49: one screening mammogram and clinical breast exam every two years (annually if high risk)</li> <li>• Females ages 50-64: one screening mammogram and clinical breast exam every 12 months</li> <li>• Males: prostate screening as specified in state law</li> </ul>
Age 65 and older	<ul style="list-style-type: none"> <li>• One influenza immunization every year</li> <li>• One pneumococcal vaccine at or after age 65</li> <li>• Females: screening pap smears not to exceed one per year</li> <li>• One TD every ten years</li> <li>• One age appropriate health maintenance visit per year (excludes lab and x-ray)</li> <li>• Females age 65-74: one screening mammogram and clinical breast exam every 12 months</li> <li>• Either annual fecal occult blood testing or two colorectal visualizations between ages 50-75</li> </ul>
<b>10. MATERNITY</b>	A one-time \$25 copayment for all routine prenatal visits combined; then applicable copayments for type of service
<b>11. PRESCRIPTION DRUGS <sup>6</sup></b> Level of coverage and restrictions on prescriptions	(30 day supply on new or refills) (includes contraceptives) \$10/\$40/\$60
<b>12. INPATIENT HOSPITAL</b>	\$250 per day to \$1,000 maximum per admission
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	\$150 copayment per visit

**Benefit Levels**

14. DIAGNOSTICS	
a. Laboratory and X-ray	0% to coinsurance limit
b. MRI, nuclear medicine, CT, CTA, MRA, and PET scans	\$150 copayment
15. EMERGENCY CARE <sup>7,8</sup>	\$150 copayment per visit for in- and out-of-network care
16. AMBULANCE	\$100 copayment
17. URGENT, NON-ROUTINE AFTER HOURS CARE	\$75 copayment per visit (out-of-network urgent care covered only if temporarily out of service area)
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>9</sup>	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE	Non-biologically based mental illness.
a. Inpatient Care	50% to coinsurance limit . (Maximum 45 inpatient or 90 days of residential or partial hospitalization per calendar year - one day of inpatient care equals two days of partial hospitalization).
b. Outpatient Care	Outpatient and Office Therapy: 50% to coinsurance limit (maximum 20 visits for \$1,500 per calendar year)
20. ALCOHOL ABUSE	50% to coinsurance limit (limited to 45 days per calendar) (including detox treatment)
21. OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	\$25 copayment per visit (limited to 25 visits per therapy per year)
22. DURABLE MEDICAL EQUIPMENT	20% to coinsurance limit (limited to \$2,000 per calendar year per covered person) See policy for types and circumstances of coverage
23. OXYGEN	20% to coinsurance limit Benefit applies to and is limited by the durable medical equipment maximum of \$2,000 per calendar year
24. ORGAN TRANSPLANTS	20% to coinsurance limit See policy for types and circumstances of coverage
25. HOME HEALTH CARE	0% to coinsurance limit (limited to 60 visits per calendar year)
26. HOSPICE CARE	0% to coinsurance limit (short-term crisis payable to 30 days per calendar year)
27. SKILLED NURSING FACILITY CARE	\$50 copayment per day (limited to 100 days per calendar year).
28. DENTAL CARE	No coverage except for dental care needed as a result of an accident.
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	Excluded
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	
a. Spinal manipulation	\$25 copayment
b. Allergy injections and serum in the doctor's office	20% to coinsurance limit
c. Second Opinion	20% to coinsurance limit

## Part C: Limitations and Exclusions

32. Period during which pre existing conditions are not covered. <sup>10</sup>	Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. How does the policy define a "pre-existing condition"?	Not applicable; plan does not exclude coverage for pre-existing conditions.
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 then to see if a service or treatment you may need is excluded from the policy.

## Part D: Using the Plan

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
37. Is prior authorization required for surgical procedures and hospital care ( <i>except in an emergency</i> )?	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
39. What is the main Customer Service number?	1-800-558-4444
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Humana Insurance Company Grievance and Appeals Office P.O. Box 14610 Lexington, KY 40512-4610 1-800-558-4444
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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 # CO-57314-07 E et al group - all sizes
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" 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" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles 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.
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