

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? ¹	Yes, but patient pays more for out-of-network care																																																					
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas (counties): 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 ^{2,3,3A}	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 ^{3b}	\$1,500	\$3,000
b. Family ^{3c}	\$4,500	\$9,000
5. ENROLLEE OUT-OF-POCKET ANNUAL MAXIMUM ⁴	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	\$4,500	\$9,000
b. Family	\$9,000	\$18,000
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 ⁵	0% after office visit copayment	50% to coinsurance limit after deductible
9. PREVENTIVE CARE ⁶		
a. Children's services	0% after \$30 copayment per visit	50% to coinsurance limit (no deductible)
b. Adults' services	0% after \$30 copayment per visit	50% to coinsurance limit
c. Colorectal screening services ^{5a, 5b}	0% after office visit copayment	0% after office visit copayment
		(\$250 copayment for outpatient/ambulatory surgery procedures, not subject to deductible)
All Persons	<ul style="list-style-type: none"> • Colorectal screening for all high risk individuals, regardless of age. • Chicken pox vaccination for all persons who have not had chicken pox. 	
Females	<ul style="list-style-type: none"> • Full cost of cervical cancer vaccine. 	
All Children	<ul style="list-style-type: none"> • Immunizations, including the influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP/AAP/AAFP. • Immunization deficient children are not bound by "recommended ages" on ACIP/AAP/AAFP chart. 	
Age 0-12 months	<ul style="list-style-type: none"> • One newborn home visit during first week of life if newborn is released from hospital less than 48 hours after delivery. • 6 well child visits (excludes lab and x-ray) • One PKU 	
Age 13-35 months	<ul style="list-style-type: none"> • Three well child visits (excludes lab and x-ray) 	
Age 3-6	<ul style="list-style-type: none"> • Four well child visits (excludes lab and x-ray) 	
Age 7-12	<ul style="list-style-type: none"> • Four well child visits (excludes lab and x-ray) 	
Age 13-18	<ul style="list-style-type: none"> • One age appropriate health maintenance visit every year (excludes lab and x-ray) • One TD • Females: screening pap smears not to exceed one per year • One hepatitis B vaccination if not given previously • Age 18: Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services • Age 18: Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services 	
Age 19-39	<ul style="list-style-type: none"> • One TD every ten years • One age appropriate health maintenance visit every three years (exclude lab and x-ray) • Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP/AAP/AAFP • Screening for lipid disorders if at an increased risk for coronary heart disease • Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services • Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services • Males ages 35-39: screening for lipid disorders • Females: screening pap smears not to exceed one per year 	

	In-Network	Out-of-Network
Age 40-64	<ul style="list-style-type: none"> • One TD every ten years • One age appropriate health maintenance visit every 24 months (exclude lab and x-ray) • Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP/AAP/AAFP • Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services • Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services • Ages 50-64: Colorectal screening • Females: Screening for lipid disorders if at an increased risk for coronary heart disease • Males: screening for lipid disorders • Females: screening pap smears not to exceed one per year • Females ages 40-64: One screening mammogram and clinical breast exam every 1 to 2 years (annually, if at high risk) • Males: prostate screening as specified in state law 	
Age 65 and older	<ul style="list-style-type: none"> • One TD every ten years • One age appropriate health maintenance visit every year (exclude lab and x-ray) • Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP/AAP/AAFP • Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services • Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services • Ages 65-75: Colorectal screening • Females: Screening for lipid disorders if at an increased risk for coronary heart disease • Males: screening for lipid disorders • Females: screening pap smears not to exceed one per year • Females ages 40-64: One screening mammogram and clinical breast exam every 1 to 2 years (annually, if at high risk) • Males: prostate screening as specified in state law 	
10. MATERNITY ⁶		
a. Prenatal	20% to coinsurance limit (a one time \$30 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	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 ^{7, 8} Level of coverage and restrictions on prescriptions	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 ⁹ a. Laboratory and X-ray b. MRI, nuclear medicine, CT, CTA, MRA, and PET scans ^{9a}	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 ^{10, 11}	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 ¹²	Coverage is no less extensive than the coverage provided for any other physical illness. All other mental illnesses (see footnote #5) 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 #5) under the certificate of Insurance are non-biologically based.

	In-Network	Out-of-Network
19. OTHER MENTAL HEALTH CARE ¹³	Non-biologically based mental illness	Non-biologically based mental illness
a. Inpatient care ¹⁴	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) ¹⁵	50% to coinsurance limit after deductible (Acute Detoxification only-5 days per episode; two episodes per lifetime in and out-of-network combined) ¹⁵
21. OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY ¹⁶	20% to coinsurance limit after deductible (limited to 25 visits per therapy per year)	50% to coinsurance limit after deductible
22. DURABLE MEDICAL EQUIPMENT ¹⁷	20% to coinsurance limit after deductible Maximum in and out of network combined benefit per calendar year of \$2,500 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 \$2,500 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 \$2,500 per calendar year.	50% to coinsurance limit after deductible Benefit applies to and is limited by the durable medical equipment maximum of \$2,500 per calendar year.
24. ORGAN TRANSPLANTS ¹⁸	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 ^{18a}	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 ¹⁹	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	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 ^{20a}	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 ^{20b}		
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. ²¹	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?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents ^{20a} and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids ^{21a} and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws ²² ; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.

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?	Yes	No
37. Is prior authorization required for surgical procedures and hospital care (<i>except in an emergency</i>)?	Yes	No
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? ²³	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?	Contact: Colorado Division of Insurance Consumer Affairs Section 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7490 Toll-free (in state): 800-930-3745 Email: Insurance@dora.state.co.us Fax: 303-894-7455	

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 the 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. Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ONLY IF plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.
3. "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).
- 3a. "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 should be noted in boxes 8 through 31.
- 3b. "Individual" means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.
- 3c. "Family" is the maximum deductible amount that is required to be met for all family members covered on a aggregate basis.
4. "Out-of-pocket maximum" refers to the maximum amount you will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. The copays for other than prescription drugs are applied to the out-of-pocket maximum on the HMO plan only.
5. "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.
- 5a. As of January 1, 2010 includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B: recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 of Colorado Insurance Regulation 4-6-5 for the list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24.
- 5b. Benefits provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.
6. Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.
7. Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders as required by §10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold group health plan in Colorado. Coverage levels for injectable drugs are based on the place of service (office: included under the office visit copay; pharmacy: covered at appropriate copay based on drug type).
8. Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred. Additionally, as noted above in footnote 4, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.
9. Includes low dose mammography screening as mandated by Colorado law, §10-16-104(18)(b)(III), C.R.S. Diagnostic services do not include therapeutic treatment.
- 9a. Covered procedures are: MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans.
10. "Emergency care" means all services delivered in 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.
11. Non-emergency care delivered in an emergency care facility is covered only if the covered person receiving such care was referred to the emergency care facility by his/her carrier or primary care physician. If emergency care facilities are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.
12. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount you pay shall not exceed 50% of the charge for any single office visit.

13. Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.
14. The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.
15. Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S.
16. Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).
17. Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetic devices does not apply to the annual DME cap. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.
18. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.
- 18a. Covered services are defined in Colorado Insurance Regulation 4-2-8.
19. Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.
20. Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.
- 20a. Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.
- 20b. Hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits are provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.
21. "Waiver of pre-existing condition 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.
- 21a. Only hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S.
22. Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage if such proof is required on the HMO's other small employer plans.
23. Grievances. Colorado law requires all plans to use consistent grievance procedures. Contact the Colorado Division of Insurance for a copy of those procedures.



Insured by Humana Insurance Company