

Humana Insurance Company

Name of Carrier

Short Term 100/75 plan

Name of Individual Health Plan

Part A: Type of Coverage

1. Type of plan	Preferred Provider Plan
2. Out-of-network care covered? (1)	Yes, but the patient pays more for out-of-network care
3. Areas of Colorado where plan is available	Plan is available throughout Colorado

Part B: Summary of Benefits

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

	In-Network	Out-of-Network
4. Deductible Type (2)	Plan Year	Plan Year
4A. Plan deductible (2a)		
a. Individual (2b)	\$1,000/\$2,500/\$5,000	\$2,000/\$5,000/\$10,000
b. Family (2c)	\$2,000/\$5,000/\$10,000	\$4,000/\$10,000/\$20,000
	Two family members must meet their individual deductible	
5. Out-of-pocket plan maximum (3)		
a. Individual	Not applicable	\$5,000
b. Family	Not applicable	\$10,000
c. Is deductible included in the out-of-pocket maximum?	Does not include deductible or copayments	
6. Lifetime benefit maximum paid by the plan for all care	\$2,000,000 (combined in and out of network)	
7A. Covered providers	Humana/ChoiceCare® network See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable	Not applicable

		In-Network	Out-of-Network
8. Medical office visits (4)			
a. Primary Care Providers	100% after deductible. Primary care providers include family practitioner, general practitioner, gynecologist, pediatrician or internist; specialist contains any other participating physician. Please contact Customer Service for details.	75% after deductible	
b. Specialists	100% after deductible. Primary care providers include family practitioner, general practitioner, gynecologist, pediatrician or internist; specialist contains any other participating physician. Please contact Customer Service for details.	75% after deductible	
9. Preventive care			
a. Children's services including exams, labs and immunizations (birth to age 13)	100% no deductible	75% no deductible	
1. Routine immunizations (age 13 to 18)	No coverage	No coverage	
b. Adult services			
1. Annual routine PSA and digital rectal exam	No coverage	No coverage	
2. Annual routine Pap smear, annual routine physical exam	No coverage	No coverage	
3. Routine mammogram	No coverage	No coverage	
4. Routine lab, pathology and X-ray	No coverage	No coverage	
10. Maternity			
a. Prenatal care	No coverage	No coverage	
b. Delivery	No coverage	No coverage	
c. Inpatient well-baby care (5)	100% after deductible	75% after deductible	
11. Prescription drugs (6)			
a. Each prescription or refill (up to 30-day supply)	100% after deductible	75% after deductible	
12. Inpatient hospital	100% after deductible	75% after deductible	
13. Outpatient hospital/Ambulatory surgery	100% after deductible	75% after deductible	
14. Diagnostics			
a. Laboratory and X-ray	100% after deductible	75% after deductible	
b. MRI, nuclear medicine and other high-tech services	100% after deductible	75% after deductible	
15. Emergency room (7), (8) (including physician visits)	100% after deductible	75% after deductible	
16. Ambulance (up to \$15,000 per lifetime)	100% after deductible	75% after deductible	
17. Urgent, non-routine after hours care	100% after deductible	75% after deductible	

	In-Network	Out-of-Network
18. Biologically based mental illness care	No coverage	No coverage
19. Other mental health care		
a. Inpatient care	No coverage	No coverage
b. Outpatient care	No coverage	No coverage
20. Alcohol and substance abuse		
a. Inpatient care	No coverage	No coverage
b. Outpatient care	No coverage	No coverage
21. Physical, occupational and speech therapy (limited to a combined maximum of 10 visits per benefit period)	100% after deductible	75% after deductible
22. Durable medical equipment (preauthorization required)	100% after deductible	75% after deductible
23. Oxygen (preauthorization required)	100% after deductible	75% after deductible
24. Organ transplants (preauthorization required)	100% after deductible (when services are at a National Transplant Network Provider)	75% after deductible (limited to \$35,000 per covered transplant)
25. Home health care (preauthorization required; limited to 60 visits per benefit period)	100% after deductible	75% after deductible
26. Hospice care (preauthorization required)	100% after deductible	75% after deductible
	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.	
27. Skilled nursing facility care (preauthorization required; up to 30 days per benefit period)	100% after deductible	75% after deductible
28. Dental care	No coverage	No coverage
29. Vision care	No coverage	No coverage
30. Chiropractic care (limited to a combined maximum of 10 visits per benefit period with physical, occupational, and speech therapy)	100% after deductible	75% after deductible
31. Significant additional covered services		
a. Cure and treatment of cleft lip and palate	100% after deductible	75% after deductible
b. Diabetes equipment and supplies and outpatient self-management training	100% after deductible	75% after deductible

Part C: Limitations and Exclusions

32. Period during which pre-existing conditions are not covered. (10)	This individual short term health benefit plan does not cover pre-existing conditions.
33. Exclusionary riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes
34. How does the policy define a "pre-existing condition"?	A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

Part D: Using the Plan

	In-Network	Out-of-Network
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main Customer Service number?	1-800-833-6917	
40. Whom do I write/call if I have a complaint or want to file a grievance? (11)	Write to: Humana Grievance & Appeals Office P.O. Box 14616 Lexington, KY 40512-4616 Phone: 1-800-833-6317	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy whether it is individual, small group, or large group and if it is a short-term policy.	Policy form # GN-71008-01 1/2008, individual, short term	
43. Does this plan have a binding arbitration clause?	No	

- (1) "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- (2) "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".
- (2a) "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.
- (2b) "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
- (2c) "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3,000 per family) or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
- (3) "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.
- (4) Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
- (5) Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
- (6) Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.
- (7) "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- (8) Nonemergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for nonemergency after-hours care, then urgent care copayments apply.
- (9) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder.
- (10) Waiver of pre-existing conditions exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
- (11) Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.



Insured by Humana Insurance Company

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Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.