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Colorado

Autograph™ Share 80 Plus Rx and Copay

HUMANA one

A plan that fits your lifestyle and budget

With Share 80 Plus Rx and Copay, get a great blend of features and benefits including:

- Two deductible options
- 80% coverage for most covered in-network medical costs after deductible
- In-network office visits (limited)
- A prescription drug benefit
- Coverage for annual exams and physicals
- Optional benefits like dental and life at an additional cost

HumanaOne COLORADO

Autograph Share 80 Plus Rx and Copay

	Plan pays for services at ***NETWORK*** providers (13)		Plan pays for services at ***NON-NETWORK*** providers (14)	
Annual Deductible (1), (2)	**Single Deductible**	**Family Deductible** (3)	**Single Deductible**	**Family Deductible** (3)
• Annual amount *(does not apply to maximum out-of-pocket expense)*	$ 5,000 6,000	$ 10,000 12,000	$10,000 12,000	$ 20,000 24,000
• Deductible Carryover	Covered expenses incurred in the last three months of the calendar year and applied to the deductible will be credited to the next calendar year deductible.			
Maximum Out-of-Pocket Expense Limit (1), (2)				
• Individual	$2,000		$8,000	
• Family	$4,000		$16,000	
Lifetime Maximum Benefit	$5,000,000 per covered person			
Preventive Care				
• Well-child care *(including immunizations) (birth to age 13)* • Routine annual PSA and digital rectal exam (6) • Routine annual mammograms (6)	**80%**		**60%**	
• Routine annual physical exam *(age 13 and older)* (5) • Routine immunizations *(age 13 to age 18)* (5) • Routine Pap smears (5) (6)	**80%**		Not Covered	
• Routine lab, pathology and X-ray (5)	**80%** after deductible		Not Covered	
Physician Services				
Office visits: (2), (16), (17)				
• Primary Care *(limited to 6 combined (Primary Care and Specialty Care) visits/ calendar year) (includes allergy injections)*	$35 copayment for 6 visits, then **80%** after deductible		**60%** after deductible	
• Specialty Care *(limited to 6 combined (Primary Care and Specialty Care) visits/ calendar year) (includes allergy injections)*	$50 copayment for 6 visits, then **80%** after deductible		**60%** after deductible	
• Diagnostic lab, X-ray and allergy testing (11), (17)	First $200 per calendar year at **100%** then **80%** after deductible		**60%** after deductible	
• Allergy serum • Inpatient services • Outpatient services *(includes surgery)*	**80%** after deductible		**60%** after deductible	
Hospital Services				
• Inpatient care • Outpatient surgery – facility • Outpatient nonsurgical • Newborn hospital stay (12)	**80%** after deductible		**60%** after deductible	
• Emergency room *(including physician visits)*	**80%** after $75 copayment per visit and deductible *(copayment waived if admitted)*		**60%** after $75 copayment per visit and deductible *(copayment waived if admitted)*	
Prescription Drugs (7)				
• Prescription drug deductible *(Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts.)* (2)	$1,000 prescription drug deductible per individual			
• Benefit for each prescription or refill *(up to 30-day supply)*	**100%** after:		**70%** after:	
– Level One - lowest copayment for lowest cost generic and brand-name drugs	$15 copayment *(not subject to prescription drug deductible)*		$15 copayment *(not subject to prescription drug deductible)*	
– Level Two - higher copayment for higher cost generic and brand-name drugs	$35 copayment after prescription drug deductible		$35 copayment after prescription drug deductible	

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.

Autograph Share 80 Plus Rx and Copay	**Plan pays for services at *NETWORK* providers (13)**	**Plan pays for services at *NON-NETWORK* providers (14)**
Prescription Drugs (7) *(continued)*		
– Level Three - higher copayment than Level Two for higher cost, mostly brand-name drugs that may have generic or therapeutic equivalents in Levels One or Two	$55 copayment after prescription drug deductible	$55 copayment after prescription drug deductible
– Level Four - highest copayment for high-technology drugs *(certain brand-name drugs, biotechnology drugs and self-administered injectable medications)*	**25%** copayment after prescription deductible up to $2,500 maximum out-of-pocket per calendar year	**25%** copayment after prescription deductible up to $2,500 maximum out-of-pocket per calendar year
• Mail order *(90-day supply)*	**100%** after three times the retail copayment	**70%** after three times the retail copayment
Other Medical Services		
• Skilled nursing facility *(up to 30 days per calendar year)* (8) • Home healthcare *(up to 60 visits per calendar year)* (8) • Durable medical equipment (8) • Hospice (8), (9) • Complications of pregnancy and sick baby services	**80%** after deductible	**60%** after deductible
• Transplant services *(organ)* (8)	**80%** after deductible *(when services are performed at a National Transplant Network provider)*	**60%** after deductible *(limited to $35,000 per covered transplant)*
Mental Health *(includes mental disorders, alcohol and chemical dependence)*		
• Inpatient and Outpatient care *(Combined $2,500 per calendar year maximum. Outpatient care not to exceed $500 of the $2,500 calendar year maximum.)*	**50%** after deductible	**50%** after deductible
Optional Benefits (10)		
• Prescription drug, $500 deductible	Under this option, $500 deductible is required to be met before plan benefits are payable.	
• Lifetime maximum benefit	$8,000,000 per covered person	
• $500 Supplemental Accident Benefit *(Treatment must be provided within 90 days of the injury.)*	First $500 per accident at **100%**, then base plan benefits apply	
• $1,000 Supplemental Accident Benefit *(Treatment must be provided within 90 days of the injury.)*	First $1,000 per accident at **100%**, then base plan benefits apply	

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.

Optional Dental benefits *(with teeth whitening)* (15)

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 75,000 dentist locations in the PPO network. You can find a dentist by visiting **Humana.com**.

Preventive services plan pays **100%** no deductible
- Oral examinations
- Routine cleanings
- X-rays
- Sealants
- Topical fluoride treatment

Basic services plan pays **50%** after deductible
- Emergency exams and palliative care for pain relief
- Thumb sucking and harmful habit appliances
- Space maintainers
- Amalgam, composite fillings
- Oral surgery
- Extractions (routine)
- Non-cast stainless steel crowns
- Partial or complete denture repairs/adjustments

Teeth whitening services plan pays **50%** after deductible
- $200 lifetime maximum

Major services plan pays **50%** after deductible
- Endodontics (root canals)
- Periodontics
- Crowns
- Inlays and onlays
- Partial or complete dentures
- Denture relines/rebases
- Removable or fixed bridgework

Orthodontia discount
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 benefit
- **$1,000**

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.

(1) When you obtain care from non-network providers:
– 50 percent of your payment toward the deductible is credited to the deductible for network providers.
– 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for network providers.
Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.

(2) Copayments do not apply to the deductible or out-of-pocket maximum. The medical out-of-pocket maximum does not apply to prescription drugs or mental health services.

(3) Two family members must meet their individual deductible.

(4) Benefit payable after a 12 month waiting period.

(5) $300 of covered expenses per person per calendar year, subject to applicable coinsurance.

(6) Age and/or frequency limits apply.

(7) If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.

(8) Prior authorization required in order to be eligible for these benefits.

(9) 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.

(10) These benefits are optional and can be added to your plan for an additional cost. Optional benefits may not be available in all areas.

(11) This benefit does not cover MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies.

(12) This benefit 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.

(13) 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.

(14) Non-network providers may balance bill you for the difference between the amount paid by us and the non-network providers billed charges if:
(a) 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;
(b) The covered person knowingly seeks services from a non-network provider; and
(c) The non-network provider is reimbursed for an amount less than the billed charge.

(15) This is not a complete disclosure of plan qualifications and limitations. Waiting periods apply: six months on basic service and teeth whitening, 12 months on major services. Please review the specific Dental limitations & exclusions before applying for coverage.

(16) Primary care physicians include family practitioner, general practitioner, gynecologist, pediatrician or internist; specialist contains any other network physician. Please contact Customer Service for details.

(17) Does not apply to preventive/routine care.

Colorado law requires 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 benefit plan of the carrier.

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

Medical Limitations and Exclusions

This is an outline of the limitations and exclusions for the Humana*One* Individual Health Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

Pre-existing conditions

A pre-existing condition is a sickness, injury or pregnancy for which a covered person incurred charges, received 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 limitations 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:

1. Services not medically necessary or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
3. 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 service that is not covered under the policy.
4. Charges in excess of the maximum allowable fee or which exceed any policy benefit maximum.
5. Expenses incurred before the effective date or after the date coverage terminated.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Any drug, medicine or device which is not FDA approved.
9. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
10. Medications, drugs or hormones to stimulate growth.
11. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness.
12. 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.
13. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
14. Drugs used in treatment of nail fungus.
15. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
16. Vitamins, dietary products and any other nonprescription supplements.
17. Infertility services.
18. Pregnancy and well-baby expenses.
19. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
20. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
21. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
22. Services received in an emergency room unless required because of emergency care.
23. Dental services (except for dental injury), appliances or supplies.
24. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
25. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
26. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
27. Nicotine habit or addiction; educational or vocation 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.
28. Foot care services.
29. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
30. 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.
31. Hair prosthesis, hair transplants or implants and wigs.
32. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
33. Injury or sickness arising out of or in 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.
34. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a mental disorder.
35. Attempted suicide or intentionally self-inflicted injury, while sane.
36. Charges covered by other medical payments insurance.
37. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
38. 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.

Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the Humana*One* 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.

Humana*One* plans at a glance[1]

	In-Network Coinsurance		In-Network Plan Deductible		HSA-Qualified	Separate Prescription Deductible (copays apply)	In-Network Office Visit Copayment	Lifetime Maximum (per individual)
	Health Plan Pays (copays may apply)	You Pay	Single	Family				
Portrait Share 80 Plus Rx and Copay	80%	20%	$1,000 or $2,500	$2,000 or $5,000	N/A	$500 (per individual)	unlimited	$5 million
Autograph Total Plus Rx/ HSA	100%	0%	$1,500, $2,500, $3,500 or $5,000	$3,000, $5,000, $7,000 or $10,000	✔	Rx applies to medical deductible	N/A	$5 million
Autograph Total/HSA	100%	0%	$2,000, $3,000, $4,000 or $5,200	$4,000, $6,000, $8,000 or $10,400	✔	N/A	N/A	$2 million
Autograph Share 80/HSA	80%	20%	$2,000 or $3,000	$4,000 or $6,000	✔	N/A	N/A	$2 million
Autograph Share 80 Plus Rx and Copay	80%	20%	$5,000 or $6,000	$10,000 or $12,000	N/A	$1,000 (per individual)	6 visits per year	$5 million
Autograph Share 70 Plus Rx	70%	30%	$2,500 or $5,000	$5,000 or $10,000	N/A	$1,000 (per individual)	N/A	$2 million
monogram Total Plus Rx	100%	0%	$7,500	$15,000	N/A	$1,000 (per individual)	N/A	$2 million

[1] The above chart is not all-inclusive. Limitations, exclusions and waiting periods apply. For a list of covered benefits including out-of-network coverage please refer to page 3 & 4 of this booklet.

Shape your plan with these optional benefits[2]:

- **Dental Insurance**
- **Decreased Prescription Deductible**
- **Term Life Insurance**
- **Supplemental Accident Benefit**
- **Increased Lifetime Maximum**

[2] Optional benefits can vary by state and/or plan, and are available at an additional cost.

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, terms and conditions of the policy will govern. All applications are subject to approval. Waiting periods, limitations and exclusions apply.

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CO-70141-HD, et al

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