

Humana Insurance Company

Name of Carrier

**Autograph Share 70 Plus Rx**

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	<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 and copayment options reflect the amount the covered person will pay**

	In-Network	Out-of-Network
4. Deductible Type (2)	Calendar Year	Calendar Year
4A. Annual deductible (2a)		
a. Individual (2b)	\$2,500/\$5,000	\$5,000/\$10,000
b. Family (2c)	\$5,000/\$10,000	\$10,000/\$20,000
	Two family members must meet their individual deductible	
	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.	
5. Out-of-pocket annual maximum (3)		
a. Individual	\$3,000	\$10,000
b. Family	\$6,000	\$20,000
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) \$5,000,000 (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.

	In-Network	Out-of-Network
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
8. Medical office visits (4)		
a. Primary Care Providers	30% after deductible	50% after deductible
b. Specialists	30% after deductible	50% after deductible
9. Preventive care		
a. Children's services including exams and immunizations (birth to age 13)	30% no deductible	50% no deductible
b. Adult services		
1. Annual routine PSA and digital rectal exam	30% no deductible	50% no deductible
2. Routine immunizations (age 13 to 18) (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)	30% no deductible	No coverage
3. Annual routine Pap smear, annual routine physical exam (age 13 and older) (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)	30% no deductible	No coverage
4. Routine mammogram	30% no deductible	50% no deductible
5. Routine lab, pathology and X-ray (up to a combined maximum of \$300 per person per calendar year subject to coinsurance)	30% after deductible	No coverage
10. Maternity		
a. Prenatal care	No coverage	No coverage
b. Delivery	No coverage	No coverage
c. Inpatient well-baby care (5)	30% after deductible	50% after deductible
11. Prescription drugs (6)		
a. Annual deductible (separate from medical deductible; medical deductibles and out-of-pocket amounts do not apply)	\$1,000 prescription drug deductible per individual	
b. Each prescription or refill (up to 30-day supply)	0% after:	30% after:
- Level One	\$15 copayment	\$15 copayment
- Level Two	\$40 copayment after prescription drug deductible	\$40 copayment after prescription drug deductible
- Level Three	\$65 copayment after prescription drug deductible	\$65 copayment after prescription drug deductible
- Level Four	25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year	25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year
Mail order (90-day supply)	Three times the retail copayment	Three times the retail copayment
12. Inpatient hospital	30% after deductible	50% after deductible

	In-Network	Out-of-Network
13. Outpatient hospital/Ambulatory surgery	30% after deductible	50% after deductible
14. Diagnostics		
a. Laboratory and X-ray	30% after deductible	50% after deductible
b. MRI, nuclear medicine and other high-tech services	30% after deductible	50% after deductible
15. Emergency room (7), (8)	30% after \$125 copayment per visit and deductible (copayment waived if admitted)	50% after \$125 copayment per visit and deductible (copayment waived if admitted)
16. Ambulance	30% after deductible	50% after deductible
	Up to \$15,000 maximum per calendar year	
17. Urgent, nonroutine after hours care	30% after deductible	50% after deductible
18. Biologically based mental illness care (9)	See #19, Other mental health care	See #19, Other mental health care
19. Other mental health care		
a. Inpatient care	50% after deductible	50% after deductible
	Up to \$2,500 combined inpatient and outpatient care maximum per calendar year for all mental health, alcohol and substance abuse benefits	
b. Outpatient care	50% after deductible	50% after deductible
	Not to exceed \$500 of the \$2,500 inpatient and outpatient care combined maximum per calendar year for all mental health, alcohol and substance abuse benefits.	
20. Alcohol and substance abuse		
a. Inpatient care	See #19, Other mental health care	See #19, Other mental health care
	Up to \$2,500 combined inpatient and outpatient care maximum per calendar year for all mental health, alcohol and substance abuse benefits	
b. Outpatient care	See #19, Other mental health care	See #19, Other mental health care
	Not to exceed \$500 of the \$2,500 inpatient and outpatient care combined maximum per calendar year for all mental health, alcohol and substance abuse benefits.	
21. Physical, occupational and speech therapy	30% after deductible	50% after deductible
	20 visit limit combined with Chiropractic Services; Cognitive and Audiology Therapy	
22. Durable medical equipment	30% after deductible	50% after deductible
23. Oxygen	30% after deductible	50% after deductible
24. Organ transplants	30% after deductible (when services are at a National Transplant Network Provider)	50% after deductible (limited to \$35,000 per covered transplant)
25. Home health care	30% after deductible	50% after deductible
	Limited to 60 visits per calendar year	
26. Hospice care	30% after deductible	50% 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	30% after deductible	50% after deductible
	Up to 30 days per calendar year	
28. Dental care	30% after deductible	50% after deductible
	For injury and for outpatient hospital and anesthesia for a covered dependent	

	In-Network	Out-of-Network
29. Vision care	No coverage	No coverage
30. Chiropractic care See #21 for visit limitation	30% after deductible	50% after deductible
31. Significant additional covered services		
a. Cure and treatment of cleft lip and palate	30% after deductible	50% after deductible
b. Diabetes equipment and supplies and outpatient self-management training	30% after deductible	50% after deductible
c. Annual routine PSA and digital rectal exam for males 50 years of age or older, or over age 40 if in a high risk category.	30% no deductible	50% no deductible
d. Baseline mammogram for females between the ages of 35 and 40 and an annual mammogram for females 40 years of age or older.	30% no deductible	50% no deductible
e. Optional Supplemental Accident Benefit (Treatment must be provided within 90 days of the injury)	Option not selected First \$500 per accident at 0%, then base plan benefits apply First \$1,000 per accident at 0%, then base plan benefits apply	

## Part C: Limitations and Exclusions

32. Period during which pre-existing conditions are not covered. (10)	Twelve months for all pre-existing conditions unless the covered person is a HIPAA eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33. Exclusionary riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA eligible individual as defined under federal and state law.
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-70129 et al, individual	
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

Local Contact at Regional Office  
 8400 East Prentice Avenue, Suite 1400 • Englewood, CO 80111-2926  
 Local: 303-694-1044 • Toll-Free: 800-825-7496

**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.**

# HumanaOne Agent Commission Schedule

## HumanaOne medical base commissions

New business with effective dates on or after January 1, 2008. The following commission schedule applies to HumanaOne policies in all states except those listed below:

<b>First-year commission</b>	<b>Subsequent year commission</b>
20% of manual premium	5% of manual premium

### Georgia:

<b>First-year commission</b>	<b>Subsequent year commission</b>
17% of manual premium	8% of manual premium

### Nevada:

<b>First-year commission</b>	<b>Subsequent year commission</b>
20% of manual premium	10% of manual premium

Mandated plan offering commission schedules:

	<b>First-year commission</b>	<b>Subsequent year commission</b>
Ohio Basic & Standard plans (for non-federally eligible insureds only)	5% of manual premium	4% of manual premium
Tennessee High & Low plans	20% of manual premium	5% of manual premium
Utah Basic plan	20% of manual premium	5% of manual premium
Virginia Guarantee Issue plans	20% of manual premium	5% of manual premium
Nevada Basic & Standard plans	20% of manual premium	10% of manual premium

No commissions are payable on HumanaOne basic plans, standard plans, high plans, low plans, guarantee issue plans, or any other mandated plan offerings not listed above. HumanaOne commissions are based on manual premium. Manual premium does not include any underwriting factors.

Commission is also paid on the dental option that insureds may elect on HumanaOne medical policies. Commissions on the dental option are paid according to the same schedule as the medical plan selected. Please see your HumanaOne sales representative for more details. For questions regarding agent licensing and commissions, please call Agency Management at 1-800-558-4444, ext. 8919, or send a fax to 1-920-339-7953.

## HumanaOne life base commissions

	<b>First-year</b>	<b>Year two to five</b>
Percent of earned premium	90%	2%

Individual life commissions are only payable during the first five policy years. No commissions will be paid after five policy years. This schedule applies only to HumanaOne individual life policies, and commissions for the HumanaOne individual life term rider are included in HumanaOne medical premiums and paid under the HumanaOne medical commission schedule.



# HumanaOne Agent Commission Schedule

## General compensation policies

**Humana believes that agents should fully disclose to the insured or applicant the programs under which they are compensated including base commissions, bonuses, incentives or other forms of remuneration for which the agent is eligible for the sale or renewal of insured products.**

The provisions of Humana's Group Producing Agent/Agency Contract apply to all commission, bonus, and recognition programs. Commissions calculated as a percentage of premium are based on paid premium only. If commission rates are not shown in the schedule or if special premium rate quotes are made, commission rates may be fixed by Humana. Agents are responsible for knowing and complying with all applicable state regulations regarding licensing and appointment.

To receive commissions and bonuses, and to be eligible for recognition programs, the producer's name must appear as agent of record on the insurance application. Humana reserves the right to exclude any policy from eligibility for commission, bonus, or recognition programs at the company's sole discretion.

In the event a policy lapses because premium is not paid and the policy is reinstated, commission on the new or reinstated policy is payable only at Humana's discretion. If it is necessary to rescind coverage for any policy, the producer shall promptly refund to Humana any commissions received on account of the policy.

If policy coverage is surrendered, rescinded, or cancelled and premiums are refunded or waived, the producer will, in all policies, lose all rights to corresponding commissions and will repay commissions to Humana on demand. Commissions paid in error or overpayments must be repaid on request. Humana may withhold all commissions, bonuses, and other compensation otherwise due the agent or agency until the overpayment is repaid in full.

The producer will pay over promptly to Humana all premiums received or collected on behalf of the company, and shall not deduct or retain commissions. No commissions will be payable on premiums refunded for any reason. There will be no additional compensation or reimbursement to the producer for expenses incurred in performing services.

Policies converted from one Humana subsidiary to another, or from one product to another, are not considered new business for commission or recognition purposes. Commission and bonus schedules are not affected by off-cycle renewals or a coverage change to a different product within a product line if there is no lapse in coverage. The policy's initial effective date will continue to control commission and bonus schedules.

Policies that are split between agents for commission purposes also are considered split for all bonus and recognition program calculations.

Humana and its subsidiaries are the final arbiter of any issues related to commission or bonus programs. Humana and its subsidiaries reserve the right to modify or terminate commissions, bonuses, and any other part of the Producer Partnership Plan at any time with 30 days notice for all policies, including existing business, regardless of the effective date of coverage.

To sell Humana products, you must be contracted and appointed with our company. Humana reserves the right to decline contracting or appointing any agent or agency at its discretion. Contact your sales representative for more information on becoming an active agent.

## HumanaOne individual insurance products provisions

The provisions in this section apply only to HumanaOne Individual Medical Policies. HumanaOne individual medical product commissions are based on "manual premiums"

### Continuation of commissions for HumanaOne individual medical policies

For agents whose appointment with HumanaOne has been terminated, the agent of record will be eligible to receive commissions for HumanaOne individual medical policies that are in-force provided that all of the following conditions are met at the time of the commission payment:

- › The agent of record has a minimum of 10 HumanaOne medical policies in-force.
- › No more than 25 percent of the agent of record's in-force HumanaOne medical policies have canceled in the past 12 months.

If a member terminates his or her health plan and continues with the dental policy option, the HumanaOne individual medical policies provision will be followed.