

Colorado

Deductible options¹ • per calendar year • copayments do not apply	• individual	\$7,500	\$15,000								
	• family (two family members must each meet their individual deductible)	\$15,000	\$30,000								
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.										
Office visit copayment		Not applicable	Not applicable								
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$0	\$5,000								
	• family	\$0	\$10,000								
Preventive care	• Well-child care (including immunizations) (birth to age 13) • prostate screening and digital rectal exam ² • mammogram ²	100%	75%								
	• preventive office visits (age 13 and older) ³ • routine immunizations (age 13 to age 18) ³ • Pap smears ^{2,3}	100%	Not covered								
	• preventive lab and X-ray ³	100% after deductible	Not covered								
Physician services	• office visits (including allergy injections) • diagnostic lab and X-ray ⁴ • allergy testing • allergy serum • inpatient and outpatient services, surgery	100% after deductible	75% after deductible								
Facility services	• inpatient and outpatient services • outpatient surgery • newborn hospital stay ⁵	100% after deductible	75% after deductible								
	• emergency services (copayment waived if admitted)	100% after \$125 copayment per visit and deductible	75% after \$125 copayment per visit and deductible								
Rx4 prescription drug⁶ • medical out-of-pocket maximum does not apply	• deductible per individual	Separate \$1,000 deductible*									
	• copay for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply)	<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Level 1</th> <th>Level 2</th> <th>Level 3</th> <th>Level 4</th> </tr> </thead> <tbody> <tr> <td>\$15*</td> <td>\$40</td> <td>\$65</td> <td>25%</td> </tr> </tbody> </table>		Level 1	Level 2	Level 3	Level 4	\$15*	\$40	\$65	25%
	Level 1	Level 2	Level 3	Level 4							
	\$15*	\$40	\$65	25%							
• copayment maximum (applies to Level 4 drugs only)	\$2,500 per individual per calendar year										
• benefit per prescription or refill	100% after prescription copayment	70% after prescription copayment ⁷									
Other medical services • prior authorization required in order to be eligible for these benefits	• mail order (up to 90-day supply)	100% after three times retail copay	70% after three times retail copay ⁷								
	• skilled nursing facility (up to 30 days per calendar year) • hospice ⁸ • home health care (up to 60 visits per calendar year) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)	100% after deductible	75% after deductible								
	• transplant services	100% after deductible when services are received from a Humana Transplant Network provider	75% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant								
Lifetime maximum benefit		\$2,000,000 per covered person									
Mental health, chemical and alcohol dependency • \$2,500 per calendar year • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy sessions (outpatient services not to exceed \$500 of the total benefit)	50% after deductible	50% after deductible								
Optional benefits • these are available to add for an additional cost • medical out-of-pocket maximum does not apply to drug coverage	• prescription drug deductible	Not available with this plan									
	• lifetime maximum benefit	Increase to \$5,000,000 per covered person									
	• supplemental accident benefit (\$500 or \$1,000) (treatment must be provided within 90 days of the injury)	First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply									

Colorado Monogram: Total Plus Rx

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 providersOnce you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
2. Age and/or frequency limit applies
3. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
4. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
5. 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.
6. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
7. The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.
8. 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.
9. **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.**
10. **Non-network providers may balance bill you for the difference between the amount paid by us and the non-network providers billed charges if:**
 - **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**
 - **The covered person knowingly seeks services from a non-network provider; and**
 - **The non-network provider is reimbursed for an amount less than the billed charge**

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.

Medical limitations and exclusions

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

Eligibility

The issue ages for HumanaOne individual health plans are two months to 64.5 years. The maximum age for a dependent child is 25 years.

Pre-existing conditions

A pre-existing condition is a sickness or injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinarily prudent person to seek treatment, during the five-year period before the covered person's 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 limitation 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. Infertility services.
9. Pregnancy and well-baby expenses.
10. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
11. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
12. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
13. Services received in an emergency room unless required because of emergency care.
14. Dental services (except for dental injury), appliances or supplies.
15. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
16. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
17. 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.
18. 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.
19. Foot care services.
20. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
21. 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.
22. Hair prosthesis, hair transplants or implants and wigs.
23. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
24. 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.
25. Attempted suicide or intentionally self-inflicted injury, while sane.
26. Charges covered by other medical payments insurance.
27. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
28. 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.
29. Any drug, medicine or device which is not FDA approved.
30. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
31. Medications, drugs or hormones to stimulate growth.
32. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
33. 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.
34. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
35. Drugs used in treatment of nail fungus.
36. Prescription refill exceeding the numbers specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
37. Vitamins, dietary products and any other nonprescription supplements.
38. 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.

Colorado law required 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 plan of the carrier.

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



Insured by Humana Insurance Company

Applications are subject to approval. Waiting periods, limitations and exclusions apply.

The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

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.