HUMANA HEALTH PLAN, INC./HUMANA INSURANCE COMPANY: CO LG NPOS 14

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 12/01/2015
Coverage For: Individual + Family | **Plan Type:** NPOS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.humana.com** or by calling **1-866-4ASSIST (427-7478)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,500 Individual / $3,000 Family** Non-Network: **$4,500 Individual / $9,000 Family** Doesn't apply to prescription drugs and preventive services. Co-insurance and co-payments don't count toward the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Prescription drug coverage Network: **$0 Individual / $0 Family** Non-Network: **$0 Individual / $0 Family**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers **$6,250 Individual / $12,500 Family** For Non-Network providers **$9,000 Individual / $18,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-billed charges, Health care this plan doesn't cover, Penalties, Non-network transplant, Out-of-network Co-Insurance, prescription drugs, specialty drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call **1-866-4ASSIST (427-7478)** or visit us at **www.humana.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-866-4ASSIST (427-7478)** to request a copy.

Does this plan use a network of providers?	Yes. See **www.humana.com or call 1-866-4ASSIST (427-7478)** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	——————none——————
	Specialist visit	$45 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	Chiropractor Exam: $45 copay/visit	Chiropractor Exam: 50% coinsurance	——————none——————
	Preventive care / screening / immunization	No charge	50% coinsurance	limited coverage for preventive care
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	50% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com.**	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail) $25 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order)
	Level 2 - Higher cost generic and brand-name drugs	$30 copay (Retail) $75 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$50 copay (Retail) $125 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Specialty drugs	35% coinsurance	50% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————————none——————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$75 copay/visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Substance use disorder outpatient services	$30 copay/visit	50% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	$45 copay/visit	50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Manipulations and Therapies: 60 PT,OT,ST,CT, AT visit limit per year includes manips & adjustments For non-network, 10 PT,OT,CT,ST,AT visits per year includes manips & adjustments
	Habilitation services	$45 copay/visit	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	100 day limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment $750 and over
	Hospice service	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Hearing aids, unless under age 19
- Infertility treatment
- Long-term care
- Non Emergent Care received from foreign providers
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Regulatory Agencies, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202-4910, Phone: 303-894-7490 or 800-930-3745, Website: http://www.dora.state.co.us/insurance, Email: insurance@dora.state.co.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478)

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,990
- **Patient pays** $2,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$50
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$2,550**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,880
- **Patient pays** $1,520

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$20
Total	**$1,520**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers**. If the patient had received care from non-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Colorado

Colorado Supplement to the Summary of Benefits and Coverage Form

HUMANA HEALTH PLAN, INC./HUMANA INSURANCE COMPANY

Name of Carrier

CO LG NPOS 14

Name of Plan

Employer Group Policy

Policy Type

Part A: Type of Coverage

1.	TYPE OF PLAN	Point of service (POS)
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:** For the National POS Open Access Network: Adams Boulder Denver Elbert Jefferson Arapahoe Broomfield Douglas El Paso Teller

Part B: Supplemental Information Regarding Benefit

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	DESCRIPTION	WHAT THIS MEANS
4. DEDUCTIBLE PERIOD	CalendarYear	Calendar year deductibles restart each January 1.

	DESCRIPTION	WHAT THIS MEANS
5. ANNUAL DEDUCTIBLE TYPE	Individual/Family	"Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. 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)."
6. WHAT CANCER SCREENINGS ARE COVERED?	Mammogram Screening – Pap Smears – Prostate Cancer Screening	

Part C: Limitations and Exclusions

7. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED FOR COVERED PERSONS AGE 19 AND OLDER.[2]	For new plans effective 1-1-2014 and after, as well as plans that renew on or after 1-1-2014: Not applicable; plan does not impose limitation periods for pre-existing conditions. For plans which were effective prior to 1-1-2014 and have not renewed in 2014: 6 months for all pre-existing conditions.
8. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	All plans that have renewed in 2014 and any new plan of 1-1-2014: Not applicable. Plan does not exclude coverage for pre-existing condition. All plans that have not renewed in 2014 and are not new after 1-1-2014: 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 children under 19, special enrollees, or for pregnancy.
9. EXCLUSIONARY RIDERS. CAN AN INDIVIDUAL'S SPECIFIC, PRE-EXISTING CONDITION BE ENTIRELY EXCLUDED FROM THE POLICY?	No

Part D: Using the Plan

	IN-NETWORK	OUT-OF-NETWORK
10. IF THE PROVIDER CHARGES MORE FOR A COVERED SERVICE THAN THE PLAN NORMALLY PAYS, DOES THE ENROLLEE HAVE TO PAY THE DIFFERENCE?	No	Yes

	DESCRIPTION	WHAT THIS MEANS
11. DOES THE PLAN HAVE A BINDING ARBITRATION CLAUSE?	No	No

Questions: Call 1-866-427-7478 or visit us at www.humana.com.
If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850
Denver, CO 80202
303-894-7490 (in-state, toll-free 800-930-3745)
Email: insurance@dora.state.co.us

ENDNOTES:

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this 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] 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.

Offered by Humana Health Plan, Inc. and insured by Humana Insurance Company