Colorado

Humana Silver 3800/Colorado HMOx

About this plan

Humana Silver 3800/Colorado HMOx is a Health Maintenance Organization (HMO) health plan. You must choose a primary care physician (PCP) from our local network of healthcare providers who will refer you to in-network specialists or hospitals when necessary.

- This plan is a Qualified Health Plan offered by Humana Health Plan, Inc.
- This plan covers inpatient and outpatient medical services, and includes prescription drug coverage. It also provides all preventive services and includes most essential health benefits, like maternity and childbirth. It does not include children's dental. Additional information can be found at **Humana.com** or on the Health Insurance Marketplace (also known as "Exchange").

Selecting a PCP – When you apply for an HMO plan, you must select an in-network PCP who will be your first point of contact for healthcare. Together, you and your PCP can make the best decisions to manage your health and well-being, which includes your PCP making referrals to other in-network specialists.

- To search for a PCP in your area, visit **Humana.com/FindADoctor.** Use your plan's network name to locate a PCP close to home.
  - The network name is **Colorado HMOx.**

The pharmacy network – The pharmacy network name is **"Select Rx Network."** CVS, Walmart and Sam's Club pharmacies are retail pharmacies in the network. This plan also gives you access to Humana's prescription mail delivery service, Humana Pharmacy®. Visit **HumanaPharmacy.com** to learn more.

- To find an in-network pharmacy near you, visit **Humana.com/PharmacyLocator**.

Who can apply for this plan – Any individual or family can apply for this plan. There are three requirements: You must live in the U.S., you must be a U.S. citizen or national (or lawfully present), and you cannot be currently incarcerated. (**healthcare.gov**)

This plan is available in the following counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, and Weld

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Date the plan starts – The initial Open Enrollment period for 2016 coverage is November 1, 2015 to January 31, 2016. Coverage can start as early as January 1, 2016. After Open Enrollment you can enroll in individual or family coverage if you have a qualifying life event. Examples of qualifying life events are moving to a new state, certain changes in your income and changes to your family size (e.g. if you marry, divorce or have a baby). (**healthcare.gov**)

Out-of-network coverage – There is no coverage for out-of-network healthcare providers except for emergency care as defined in your policy. In addition, if you fill your prescriptions at a retail pharmacy other than CVS, Walmart or Sam's Club, or use a mail order service other than **HumanaPharmacy.com**, there is no coverage, except in an emergency as defined in your policy.

Insurance terms you should know:

Coinsurance – A percentage of your medical and drug costs that you pay out of your pocket

Copay – The fixed dollar amount you pay when you receive medical services or have a prescription filled

Deductible – The amount you pay for medical services or prescriptions before your plan pays for your benefits

Network – A group of healthcare providers or pharmacies who are contracted with Humana to provide medical services or prescription drugs at a discounted rate; often referred to as "in-network"

Maximum out-of-pocket – The most you could pay toward covered expenses including deductibles, copays and coinsurance

This document is for information only and contains a general summary of covered benefits, exclusions, and limitations. Please refer to the plan's medical insurance policy for a full list of benefits covered.

The medical insurance policy is a document that details the benefits and provisions of the plan, as well as limitations and services that are not covered. Please see the "Limitations and exclusions" that are included in this document. If there are discrepancies with the information given in this document, the terms and conditions of the medical insurance policy will apply.

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		In-network	
		Individual	**Family**
Combined medical and children's vision care deductible*	The amount of covered expenses you'll pay out of your pocket before the plan pays for covered services	$3,800	$7,600
Annual out-of-pocket maximum*	The most you pay toward the covered cost of your health care for the calendar year; includes copays, deductibles, coinsurance and pharmacy charges; does not include the premium › Once you reach your out-of-pocket maximum, the plan pays 100% of all covered expenses › Copays do not accumulate toward the deductible but they do accumulate to the out-of-pocket maximum › Deductible and out-of-pocket maximum start over each new calendar year	$6,300	$12,600
Coinsurance*	The percentage you pay for covered in-network medical services	You pay 20% of covered expenses after you pay your deductible	

* If your family is covered, the individual deductible and out-of-pocket maximum accumulate to the medical and prescription drug individual and family maximum. An individual covered family member will receive coinsurance benefits once they have met their individual deductible. The rest of the covered family members will receive coinsurance benefits once they have satisfied their individual deductible or when the entire family deductible has been satisfied.

Lifetime maximum	The total amount this plan will pay for covered expenses in your lifetime	Unlimited
Preventive care	Includes preventive office visits, lab tests, X-rays, child immunizations, flu and pneumonia immunizations, Pap tests, mammograms, prostate screening, certain endoscopic services, tobacco screening (age 18 and older) and more › A PCP referral is not required for in-network OB/GYN services	This plan pays 100%
Diagnostic visits	› Includes, but is not limited to, maternity and mental health services To search for a Primary Care Physician (PCP), Retail Clinic, Urgent Care or Specialist, go to **Humana.com/FindADoctor.** Use the plan's network name to locate a provider close to home. The network name for this plan is **Colorado HMOx.**	This plan pays 100% after you pay a copay per visit: • $20 for PCP • $30 for retail clinic • $40 for urgent care • $40 for specialist
Diagnostic lab and X-rays	› Includes allergy testing › Includes maternity and mental health services	The plan pays 100% of the first $500 per covered plan member per calendar year; then you pay 20% after you pay your deductible
	› Advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG	You pay 20% after you pay your deductible

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		In-network
Emergency room	Emergencies are life-threatening illnesses or injuries › Includes, but is not limited to, major head trauma, chest pain, severe abdominal pain, loss of consciousness, amputation of a body part, severe break or bone fracture and signs or symptoms of stroke or heart attack	$250 copay per visit then you pay 20% after you pay your deductible
	Non-emergency emergency room visits › Costs incurred will not apply toward your deductible or maximum out-of-pocket	Not covered
Ambulance		You pay 20% after you pay your deductible
Hospital stay	Inpatient › Facility fee (e.g. hospital room) › Physician/surgeon fees Outpatient › Facility fee (e.g. ambulatory surgery center) › Physician/surgeon fees	You pay 20% after you pay your deductible
Maternity	› Delivery and related inpatient and outpatient services	You pay 20% after you pay your deductible
Transplants	Benefits must be received from a Humana National Transplant Network provider	You pay 20% after you pay your deductible
Mental health	Mental illness and chemical/alcohol dependency › Includes inpatient and outpatient services	You pay 20% after you pay your deductible
Durable medical equipment	Items that are prescribed by a healthcare provider for use in a patient's home. Including, but not limited to: › Hospital beds › Nebulizers › Oxygen Equipment › Wheelchairs	You pay 20% after you pay your deductible
Other medical services	Including, but not limited to: › Skilled nursing facility – up to 100 days per calendar year › Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – separate, up to 20 visits per calendar year › Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year › Home healthcare services – up to 7 visits per week › Hospice family counseling › Hospice medical social services	You pay 20% after you pay your deductible
	› Hearing Aids for individuals under age 18	Benefit level is based upon the place of treatment

		In-network
Prescription drugs	The pharmacy network name is **"Select Rx Network"** › Prescriptions must be filled at in-network pharmacies; if you use an out-of-network pharmacy, there is no coverage except in the case of an emergency › In-network retail pharmacies are CVS, Walmart and Sam's Club pharmacies • You pay a copay or a portion of the drug cost for each covered prescription fill or refill up to a 30-day supply at these in-network pharmacies • You do not need to be a member of Sam's Club to have your prescription filled at Sam's Club pharmacies › This plan also gives you access to Humana's prescription mail delivery service, Humana Pharmacy • Visit **HumanaPharmacy.com** to learn more • Mail delivery through Humana Pharmacy covers up to a 90 day supply at 2.5 times the retail copay › The prescription drug plan name is **Rx5 Value** › Use the Rx drug list search tool at **Humana.com/DrugLookup** to find out what drugs are included; or › Visit **www.humana.com/2016-Rx5-Value** for a comprehensive listing of covered drugs	**Level 1** • $10 copay for covered preferred generic drugs **Level 2** • $20 copay for covered non-preferred generic drugs **Level 3** • $50 copay for covered preferred brand name drugs **Level 4** • $135 copay for covered non-preferred brand name drugs **Level 5** • $500 copay for covered specialty drugs
Children's vision care	Children are covered through age 19 › Exam with dilation as necessary (limit 1 per year) › Medically necessary eyeglass lenses with covered frames or contact lenses (limit 1 per year) • Eyeglass lens options – standard polycarbonate and/or standard scratch coating › If you buy a frame outside of the selection, the plan provides a benefit up to the amount that would have been paid if you chose a frame from the selection; additional discounts may be available with network providers › The above services are not all inclusive; see the plan policy for more details	You pay 50% after you pay your deductible

Connect for Health Colorado

› If coverage was purchased through Connect for Health Colorado and an Advance Premium Tax credit was received, any deductible, copay, coinsurance and/or out-of-pocket coinsurance maximum may change without notice. Connect for Health Colorado will determine if a change is to be made. We will make the change as directed.

Network agreements

Network providers (also called in-network providers) agree to accept an agreed-upon amount as payment in full. Your policy explains your share of the cost of services rendered by network providers. The plan may include a deductible, a set amount (copay), and a percent of the costs (coinsurance).

When you go to an in-network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.
- There are primary care physician (PCP) selection requirements and specialist referral requirements.
- Primary care physician (PCP) referral is not required for network obstetrician, and gynecologist services

When you go to an out-of-network provider:

- There is no coverage for out-of-network providers, except for emergency care as defined in your policy.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Certain medical services require preauthorization before services are rendered. Certain prescription drugs, Including specialty drugs, require prior authorization and may also require step therapy. Please visit **humana.com/individual-and-family** for a detailed list. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due.
- Charges in excess of the maximum allowable fee, default rate or reimbursement limit.
- Charges in excess of any benefit maximum.
- Services not authorized, furnished, or prescribed by a healthcare provider.
- Services for which no charge is made.
- Services which are not rendered by the billing provider.
- Services which are not substantiated in the medical records by the billing provider.
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary.
- Services not medically necessary, or that do not meet our medical and pharmacy coverage policies, claim payment policies or benefit policy guidelines except for routine preventive medical services as stated in the policy.
- Services that require referral from a primary care physician (PCP) if the referral was not obtained or was not approved or authorized by us prior to the service being rendered other than an in- network urgent care center or an in-network retail clinic.
- Services provided by an out-of-network provider, except when medically necessary to render emergency care as stated in the policy.

Elective and cosmetic services

- Cosmetic services, or any related complication.
- Elective medical or surgical procedures except elective tubal ligation and vasectomy.
- Hair prosthesis, hair transplants, or hair implants.
- Prophylactic services other than a prophylactic mastectomy.

Immunizations

- Immunizations except as stated in the policy.

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury and certain oral surgical procedures), appliances, or supplies.
- Foot care services.
- Hearing care that is routine except as stated in the policy; any artificial hearing device, cochlear implants, auditory prostheses or other means of auditory comprehension.
- Vision examinations or testing, eyeglasses, contact lenses, eye exercises, or any surgery or procedure to change or correct vision except as stated in the policy.

Pregnancy and sexuality services

- Elective medical or surgical abortion except as stated in the policy.
- Immunotherapy for recurrent abortion.
- Home uterine activity monitoring.
- Reversal of sterilization.
- Infertility services.
- Services rendered in a premenstrual syndrome or holistic medicine clinic.

Obesity-related services
- Any treatment for obesity.
- Surgical procedures for the removal of excess skin and/or fat due to weight loss.

Illness/injury circumstances
- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the policy.
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, or engaging in an illegal occupation.

Care in certain settings
- Private duty nursing except as stated in the policy.
- Custodial or maintenance care.
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service connected sickness or bodily injury.

Hospital services
- Pre-surgical/procedural testing duplicated during a hospital confinement.
- Services received in an emergency room unless required because of emergency care.
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
- Hospital inpatient services, including physician services, when the covered person is in observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health.

Mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services.
- Services and supplies that extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.

Other payment available
- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law.
- Charges for which any other insurance providing medical payments exists.

Services not considered medical
- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner.

Other
- Any expense incurred for services received outside of the United States except as required by law for emergency care services.
- Biliary lithotripsy; Chemonucleolysis.
- Charges for growth hormones except as stated in the policy.
- Contraceptives when prescribed for purposes other than to prevent pregnancy unless medically necessary and appropriate for the condition.
- Educational or vocational training or therapy, services, and schools.
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations.
- Genetic testing, counseling, or services except for BRCA screening, counseling, and testing recommended by the HRSA.
- Hyperhidrosis.
- Immunotherapy for food allergy.
- Light treatment for Seasonal Affective Disorder (S.A.D.).
- Living expenses, travel, transportation, except as stated in the policy.
- Prolotherapy; Sensory integration therapy.
- Services for care or treatment of non-covered procedures, or any related complication.
- Alternative medicine including but not limited to holistic medicine and naturopathy.
- Services that are experimental, investigational, or for research purposes.
- Sleep therapy.
- Treatment for TMJ except as stated in the policy, CMJ, any jaw joint problem or any orthognathic surgery.
- Treatment of nicotine habit or addiction except for as stated in the policy and smoking cessation drugs on our Preventive Medication Coverage drug list.
- Any drug and/or ingredient which is not FDA approved.
- Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
- Drugs prescribed for intended use other than for indications approved by the FDA or recognized off label indications through peer reviewed medical literature.
- Prescription fills or refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
- Vitamins, herbs, minerals, dietary supplements, nutritional products, and any other nonprescription supplements.
- Over the counter medical items, supplies, or drugs that are available without a prescription except for insulin or drugs on our Preventive Medication Coverage drug list.
- Prescription fills or refills that exceed our drug or dispensing specific limits or are refilled early.
- Drugs for which prior authorization is required if prior authorization was not obtained from us.
- Anorectic or any drug used for weight control, abortifacients, allergen extracts, or any drug not included on our drug list.
- Costs related to mailing, sending or delivery of a drug or drugs that are lost, stolen, spilled, spoiled or damaged.
- Prescription drugs filled at an out-of-network pharmacy.

Additional expenses not covered for the following benefits:

Pediatric Vision
(for plans on and off marketplace)

- Orthoptic or vision training and any associated testing.
- Multiple pair of glasses in lieu of bifocals or trifocals.
- Pre-and post-operative services; medical or surgical treatment of the eye(s) or supporting structure.
- Services or materials required by an employer; safety lenses and frames.
- Contact lenses when benefits are paid for frames and lenses.
- Separate fees for pre and post-operative services.
- Oversized 61 and above lens or lenses; artistically painted lenses; premium lens options.
- Treatment related to or caused by disease.
- Charges for missed appointments or completion of claim forms.
- Non-prescription materials or vision devices.
- Costs for securing materials; routine maintenance of materials.
- Refitting or change in lens design after initial fitting.
- Orthokeratology.
- Services provide by an out-of-network provider.
- Vision care not obtained from an in-network provider designated by us.

Pediatric Dental
(for plans off Marketplace)

- Charges for precision or semi-precision attachments, overdentures and any associated endodontic treatment, any customized attachments, temporary and interim dental services, charges related to materials or equipment used in delivery of dental care, or services for 3D imaging (cone beam images).
- Orthognathic surgery; destruction of lesions; tooth transplantation; removal of a foreign body from the oral tissue or bone; reconstruction of facial bones.
- Implants and any related services except as stated in the policy.
- Elective removal of non-pathologic impacted teeth; replacement of fillings in place less than two years.
- Infection control including but not limited to sterilization techniques.
- Charges for missed appointments or completion of claim forms.
- Charges related to altering vertical dimension of teeth or changing the spacing and/or shape of the teeth, restoration or maintenance of occlusion, splinting teeth, including multiple abutments or any service to stabilize periodontally weakened teeth, replacing tooth structures lost resulting from abrasion, attrition, erosion or abfraction, or bite registration or analysis.
- Hospital, surgical or treatment facility or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications.
- Orthodontic services or repair and replacement of orthodontic appliances.
- Preventive control programs including but not limited to oral hygiene instructions, plaque control, take-home items, or dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Services performed by other than a dentist except as stated in the policy.
- Services not eligible for benefits based on a clinical review, does not offer a favorable prognosis, or does not have uniform professional acceptance.
- Services provide by an out-of-network provider.

Offered by Humana Health Plan, Inc. an issuer in the Connect for Health Colorado. Applications are subject to eligibility requirements. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage call or write your Humana insurance agent or broker. Applications are subject to eligibility requirements. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage call or write your Humana insurance agent or broker.

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