Humana Health Plan, Inc.
Humana Silver 4125/Colorado HMOx

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO-HDHP

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 **1-800-833-6917**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,125 Individual / $8,250 Family** Doesn't apply to preventive care. Coinsurance and copayments 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,125 Individual / $8,250 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, Penalties and health care this plan doesn't cover.	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.
Does this plan use a network of providers?	Yes. See www.humana.com or call **1-800-833-6917** 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**.

Questions: Call 800-833-6917 or visit us at www.humana.com.
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Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.
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 in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not Covered	---none---
	Specialist visit	No charge after deductible	Not Covered	
	Other practitioner office visit	No charge after deductible Retail Clinic: No charge after deductible	Not Covered	Acupuncture not covered.
	Preventive care/ screening/immunization	No charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not Covered	Preauthorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-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/2016-HDHP-Value or click here	Generic and brand-name drugs	No charge after deductible	Not covered	Preauthorization may be required, penalty will be 100% for certain prescription drugs. 30 day supply (Retail) 90 day supply (Mail Order)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not Covered	---none---
	Physician/surgeon fees	No charge after deductible	Not Covered	---none---
If you need immediate medical attention	Emergency room services	No charge after deductible	No charge after deductible	---none---
	Emergency medical transportation	No charge after deductible	No charge after deductible	---none---
	Urgent care	No charge after deductible	Not Covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	Preauthorization may be required.
	Physician/surgeon fee	No charge after deductible	Not Covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	Not Covered	---none---
	Mental/Behavioral health inpatient services	No charge after deductible	Not Covered	Preauthorization may be required.
	Substance use disorder outpatient services	No charge after deductible	Not Covered	---none---
	Substance use disorder inpatient services	No charge after deductible	Not Covered	Preauthorization may be required.
If you are pregnant	Prenatal and postnatal care	No charge after deductible	Not Covered	---none---
	Delivery and all inpatient services	No charge after deductible	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Covered	Preauthorization may be required. 28 hours per week
	Rehabilitation services	No charge after deductible	Not Covered	Preauthorization may be required. - 10 visits per calendar year for spinal manipulations, adjustments, and modalities. 20 visits per calendar year for all other therapies.
	Habilitation services	No charge after deductible	Not Covered	
	Skilled nursing care	No charge after deductible	Not Covered	Preauthorization may be required. 100 days per calendar year.
	Durable medical equipment	No charge after deductible	Not Covered	Preauthorization may be required.
	Hospice service	No charge after deductible	Not Covered	Preauthorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge after deductible	Not covered	1 exam per year.
	Glasses	No charge after deductible	Not covered	1 pair of glasses/frames per year.
	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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Hearing aids
- Private-duty nursing (home health care)
- Routine eye care (Adult) when in treatment for diabetes
- Routine foot care when in treatment for diabetes
- Spinal manipulations

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-833-6917. You may also contact your state insurance department at Division of Insurance, 1560 Broadway Suite 850, Denver, CO 80202 - Phone: 303-894-7490 or 800-930-3745 - Website: www.dora.colorado.gov/insurance.

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 your state insurance department at Division of Insurance, 1560 Broadway Suite 850, Denver, CO 80202 - Phone: 303-894-7490 or 800-930-3745 - Website: www.dora.colorado.gov/insurance.

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 800-833-6917.

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** $3,265
- **Patient pays** $4,275

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	$4,125
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,275**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,195
- **Patient pays** $4,205

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	$4,125
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$4,205**

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 in-network **providers**. If the patient had received care from out-of-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 the 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.

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Supplement to the Summary of Benefits and Coverage

Colorado

Humana Health Plan, Inc.

Name of Carrier

HumanaOne HDHP HMO HSA Eligible Plan

Name of Individual Health Plan

Individual Policy

Policy Type

Type of Coverage

1.	Type of Plan	Health Maintenance Organization (HMO)
2.	Out-of-network care covered? (1)	Only for emergency and urgent care
3.	Areas of Colorado where plan is available	**Plan is available ONLY in the following areas:** **Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, Weld**

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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	Calendar Year	Calendar year deductibles restart each January 1.

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	Description	What this means.
5. Annual Deductible Type	Single Coverage/Non-single Coverage	"Single" means the deductible amount you will have to pay for allowable covered expenses under this HSA-qualified health plan when you are the only individual covered by the plan. "Non-single" is the deductible amount that must be met by one or more family members covered by this HSA-qualified plan before any covered expenses are paid.
6. What cancer screenings are covered?	Prostate, Colorectal, Breast and Cervical NOTE: This is not an all inclusive list.	

Limitations and Exclusions

7. Period during which pre-existing conditions are not covered.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No

Using the Plan

10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
11. Does this plan have a binding arbitration clause?	No

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Supplement to the Summary of Benefits and Coverage *(continued)*

Questions:

Call 1-800-833-6917 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
Call: 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 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).

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