



Simply the right plan for you

HUMANA
one

Choose the plan that's right for you



The right blend of features and benefits

- › Choice of deductibles to ensure you get the coverage you need at a price you can afford
- › Large network so you're covered when you're at home or traveling
- › Portability if you move to another state
- › Discounts on eye care and vision services
- › Optional dental, life, and prescription drug coverage available on select plans
- › Unique plan designs, like Short Term Medical and Annual Max, are available to meet your specific needs

Whether you're self-employed, an early retiree, or work for a company that doesn't offer group health insurance, look to HumanaOne for you and your family's individual insurance needs.

Our plans make it possible to find the right coverage at a price that fits your budget.

You can also expect:

- › Friendly service every time you need answers on claims, benefits, or payments
- › 12-month initial rate guarantee if you stay in the same area and keep the same benefits (on select plans)
- › Convenient application process over the phone or online (applications are subject to approval)

HumanaOne PPO plans

Portrait: Share 80 Plus Rx Unlimited

		Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰
Deductible options¹ • per calendar year • copayments do not apply	• individual	\$1,000/\$2,500	\$2,000/\$5,000
	• family (two family members must each meet their individual deductible)	\$2,000/\$5,000	\$4,000/\$10,000
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		\$35 primary care/\$50 specialist unlimited visits for illness or injury	Not applicable
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$2,000	\$8,000
	• family	\$4,000	\$16,000
Preventive care	• Well-child care (including immunizations) (birth to age 13) • prostate screening, colorectal cancer screening and digital rectal exam ² • mammogram ²	80%	60%
	• preventive office visits (age 13 and older) ³ • routine immunizations (age 13 to age 18) ³ • Pap smears ^{2,3}	80%	Not covered
	• preventive lab and X-ray ³	80% after deductible	Not covered
Physician services	• office visits (including allergy injections)	100% after office visit copayment	60% after deductible
	• diagnostic lab and X-ray ⁴ • allergy testing	First \$200 per calendar year 100% then 80% after deductible	60% after deductible
	• allergy serum • inpatient and outpatient services, surgery	80% after deductible	60% after deductible
Facility services	• inpatient and outpatient services • outpatient surgery • newborn hospital stay ⁵	80% after deductible	60% after deductible
	• emergency services (copayment waived if admitted)	80% after \$75 copayment per visit and deductible	60% after \$75 copayment per visit and deductible
Rx4 prescription drug⁶ • medical out-of-pocket maximum does not apply	• deductible per individual • copay for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply)	Separate \$500 deductible*	
		Level 1 \$15*	Level 2 \$35
		Level 3 \$55	Level 4 25%
	• copayment maximum (applies to Level 4 drugs only)	*Level 1 drugs subject to copay, no deductible \$2,500 per individual per calendar year	
	• benefit per prescription or refill	100% after prescription copayment	70% after prescription copayment ⁷
	• mail order (up to 90-day supply)	100% after three times retail copay	70% after three times retail copay ⁷
Other medical services • prior authorization required in order to be eligible for these benefits	• 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)	80% after deductible	60% after deductible
	• transplant services	80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
Lifetime maximum benefit		\$5,000,000 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	With this option no deductible is required before Rx benefits are payable	
	• lifetime maximum benefit	Increase to \$8,000,000 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	

Autograph: Share 80 Plus Rx

Monogram: Total Plus Rx

Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰	Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰
\$3,500/\$5,000/\$6,000	\$7,000/\$10,000/\$12,000	\$7,500	\$15,000
\$7,000/\$10,000/\$12,000	\$14,000/\$20,000/\$24,000	\$15,000	\$30,000
\$35 primary care/\$50 specialist limited to 6 combined primary and specialty care visits	Not applicable	Not applicable	Not applicable
\$2,000	\$8,000	\$0	\$5,000
\$4,000	\$16,000	\$0	\$10,000
80%	60%	100%	75%
80%	Not covered	100%	Not covered
80% after deductible	Not covered	100% after deductible	Not covered
100% after office visit copayment up to 6 combined primary and specialty care visits, then 80% after deductible	60% after deductible	100% after deductible	75% after deductible
First \$200 per calendar year 100% then 80% after deductible	60% after deductible		
80% after deductible	60% after deductible		
80% after deductible	60% after deductible	100% after deductible	75% after deductible
80% after \$75 copayment per visit and deductible	60% after \$75 copayment per visit and deductible	100% after \$125 copayment per visit and deductible	75% after \$125 copayment per visit and deductible
Separate \$1,000 deductible*		Separate \$1,000 deductible*	
Level 1	Level 2	Level 3	Level 4
\$15*	\$35	\$55	25%
*Level 1 drugs subject to copay, no deductible		*Level 1 drugs subject to copay, no deductible	
\$2,500 per individual per calendar year		\$2,500 per individual per calendar year	
100% after prescription copayment	70% after prescription copayment ⁷	100% after prescription copayment	70% after prescription copayment ⁷
100% after three times retail copay	70% after three times retail copay ⁷	100% after three times retail copay	70% after three times retail copay ⁷
80% after deductible	60% after deductible	100% after deductible	75% after deductible
80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant	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
\$5,000,000 per covered person		\$2,000,000 per covered person	
50% after deductible	50% after deductible	50% after deductible	50% after deductible
With this option \$500 deductible is required before Rx benefits are payable		Not available with this plan	
Increase to \$8,000,000 per covered person		Increase to \$5,000,000 per covered person	
First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply		First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply	

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.

- 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 providers

Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
- Age and/or frequency limit applies.
- Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
- MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
- 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.
- If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.
- 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.
- 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.**
- 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

HumanaOne HSA-qualified HDHP plans

Autograph: Total Plus Rx / HSA

		Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰
Deductible options¹ • per calendar year	<ul style="list-style-type: none"> individual family² 	\$1,500/\$2,500/\$3,500/\$5,000 \$3,000/\$5,000/\$7,000/\$10,000	\$3,000/\$5,000/\$7,000/\$10,000 \$6,000/\$10,000/\$14,000/\$20,000
Coinsurance out-of-pocket limit¹ • deductibles do not apply	<ul style="list-style-type: none"> individual family 	\$0 \$0	\$6,000 \$12,000
Preventive care	<ul style="list-style-type: none"> Well-child care (including immunizations) (birth to age 13) prostate screening, colorectal cancer screening and digital rectal exam³ mammogram³ preventive office visits (age 13 and older)⁴ routine immunizations (age 13 to age 18)⁴ Pap smears^{3,4} preventive lab and X-ray⁴ 	100% 100% 100% after deductible	70% Not covered Not covered
Physician services	<ul style="list-style-type: none"> office visits diagnostic lab and X-ray allergy injections, testing and serum inpatient and outpatient services surgery 	100% after deductible	70% after deductible
Facility services	<ul style="list-style-type: none"> inpatient and outpatient services outpatient surgery emergency services newborn hospital stay⁵ 	100% after deductible	70% after deductible
Prescription drug	<ul style="list-style-type: none"> retail or mail order benefit for each prescription or refill 	100% after deductible	70% after deductible ⁶
Other medical services • Prior authorization required in order to be eligible for these benefits	<ul style="list-style-type: none"> skilled nursing facility (up to 30 days per calendar year) hospice⁸ home health care (up to 60 visits per calendar year) durable medical equipment pregnancy complications and sick baby services (no prior authorization required) transplant services 	100% after deductible 100% after deductible when services are received from a Humana Transplant Network provider	70% after deductible 70% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
Lifetime maximum benefit		\$5,000,000 per covered person	
Mental health, chemical and alcohol dependency⁴ • \$2,500 per calendar year	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> lifetime maximum supplemental accident benefit (\$500 or \$1,000) (treatment must be provided within 90 days of the injury) 	Increase to \$8,000,000 per covered person First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply	

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.

- 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 providers

Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
- For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.
- Age and/or frequency limit applies.
- Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
- 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.
- If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- This value-added feature is not insurance. There is no coverage for retail and/or mail order prescription drugs unless stated in the policy.
- 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.
- 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.**

Autograph: Total / HSA

Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰
\$2,000/\$3,000/\$4,000/\$5,200	\$4,000/\$6,000/\$8,000/\$10,400
\$4,000/\$6,000/\$8,000/\$10,400	\$8,000/\$12,000/\$16,000/\$20,800
Not applicable	\$6,000
Not applicable	\$12,000
100%	70%
100%	Not covered
100% after deductible	Not covered
100% after deductible	70% after deductible
100% after deductible	70% after deductible
Discounts available ⁷	Not covered
100% after deductible	70% after deductible
100% after deductible when services are received from a Humana Transplant Network provider	70% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
	\$2,000,000 per covered person
Not covered	Not covered
Increase to \$5,000,000 per covered person	
First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply	

HSA-qualified plans

When you select an HSA-qualified High Deductible Health Plan (HDHP), you can open a Health Savings Account (HSA), a personal fund in which you set aside money for qualified healthcare expenses.

An HSA is a tax-free* way to budget and pay for your deductible and other qualified medical expenses. Even if you don't use any healthcare services now, your HSA funds will be there if you need them in the future. Unused funds roll-over year to year.

And, it's easy to use. HumanaOne can provide convenient access to banking partners where you can establish your HSA account. Or, if you prefer, you can select your own bank.

* Varies by state, please contact your tax advisor for tax deductibility.

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

HumanaOne Annual Max plans

Annual Max 75/55

		Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰								
Deductible options¹	<ul style="list-style-type: none"> individual family (three family members must each meet their individual deductible) 	\$1,000/\$2,000/\$3,000 \$3,000/\$6,000/\$9,000	\$2,000/\$4,000/\$6,000 \$6,000/\$12,000/\$18,000								
Annual maximum options	<ul style="list-style-type: none"> per calendar year all covered services apply 	\$100,000 or \$250,000 paid by plan per covered person									
Outpatient services maximum options	<ul style="list-style-type: none"> per calendar year reduces annual maximum 	\$5,000 paid by plan for \$100,000 annual maximum \$5,000 or \$10,000 paid by plan for \$250,000 annual maximum									
Coinsurance out-of-pocket limit¹	<ul style="list-style-type: none"> individual family 	\$3,500 \$7,000	\$10,000 \$20,000								
Preventive care	<ul style="list-style-type: none"> well-child care (including immunizations) (birth to age 13) prostate screening, colorectal cancer screening and digital rectal exam mammogram preventive office visits (age 13 and older)² routine immunizations (age 13 to age 18)² Pap smears² preventive lab and X-ray² 	75% 75% 75% after deductible	55% Not covered Not covered								
Physician services	<ul style="list-style-type: none"> office visits for illness or injury (including allergy injections) diagnostic lab and X-ray³ allergy testing allergy serum inpatient and outpatient services surgery emergency services 	Deductible \$1,000 or \$2,000 \$3,000 \$1,000 or \$2,000 \$3,000 \$1,000, \$2,000 and \$3,000	100% after office visit copay of \$35 for primary care and \$50 for specialty care up to 3 combined visits, then 75% after deductible 75% after deductible First \$100 per calendar year 100% then 75% after deductible ⁴ 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% after deductible							
Facility services	<ul style="list-style-type: none"> inpatient and outpatient services outpatient surgery emergency services (copayment waived if admitted) 	75% after deductible 75% after \$125 copay per visit and deductible	55% after deductible 55% after \$125 copay per visit and deductible								
Prescription drug	<ul style="list-style-type: none"> benefit maximum (per covered person per calendar year) deductible per covered person copay for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply) benefit per prescription or refill⁵ mail order (up to 90-day supply) 	\$2,500 paid by plan Separate \$500 deductible* <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 drugs subject to copay, no deductible		Level 1	Level 2	Level 3	Level 4	\$15*	\$40	\$65	25%
Level 1	Level 2	Level 3	Level 4								
\$15*	\$40	\$65	25%								
Other medical services	<ul style="list-style-type: none"> prior authorization required in order to be eligible for these benefits skilled nursing facility (up to 30 days per calendar year) hospice⁷ home health care (up to 60 visits per calendar year) durable medical equipment pregnancy complications and sick baby services⁸ (no prior authorization required) transplant services 	75% after deductible 75% after deductible when services are received from a Humana Transplant Network provider	55% after deductible 55% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant								
Lifetime maximum benefit		\$2,000,000 per covered person									
Behavioral health (mental health, chemical and alcohol dependency)	<ul style="list-style-type: none"> inpatient services outpatient and office therapy sessions 	Not covered	Not covered								
Optional benefits	<ul style="list-style-type: none"> 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									

Annual Max 50/30

Plan pays for services from NETWORK providers ⁹	Plan pays for services from NON-NETWORK providers ¹⁰
\$1,000/\$2,000/\$3,000	\$2,000/\$4,000/\$6,000
\$3,000/\$6,000/\$9,000	\$6,000/\$12,000/\$18,000
\$100,000 or \$250,000 paid by plan per covered person	
\$5,000 paid by plan for \$100,000 annual maximum	
\$5,000 or \$10,000 paid by plan for \$250,000 annual maximum	
\$3,500	\$10,000
\$7,000	\$20,000
50%	30%
50%	Not covered
50% after deductible	Not covered
50% after deductible	30% after deductible
50% after deductible	30% after deductible
50% after deductible	30% after deductible
50% after deductible	30% after deductible
50% after deductible	30% after deductible
50% after \$125 copayment per visit and deductible	30% after \$125 copayment per visit and deductible
Discounts available ⁶	Not covered
Not covered	Not covered
50% after deductible	30% after deductible
\$2,000,000 per covered person	
Not covered	Not covered

First \$500 per accident at 100%, then base plan benefits apply or
First \$1,000 per accident at 100%, then base plan benefits apply

Here's how it works:

Annual Max plans have calendar year dollar limits, or caps, that keep premiums affordable and deductibles low. When you select your Annual Max plan, it's important to remember that you are responsible for expenses that exceed these calendar year dollar limits. Create an Annual Max plan that's right for you:

- 1 Choose your deductible.** You decide which option works best for you.
- 2 Select your annual maximum amount.** This is the total amount your plan will pay for covered services each calendar year. You can select an annual maximum of \$100,000 or \$250,000.
- 3 Know your outpatient services annual maximum.** The total amount your plan pays for outpatient services is \$5,000 each calendar year. If you select the \$250,000 annual maximum option, you have the option to increase this limit to \$10,000.
- 4 Understand your prescription drug maximum**
After meeting your prescription deductible and paying applicable copayments, the 75/55 plan pays 100 percent for all covered prescriptions up to \$2,500 per calendar year.

Important information about annual maximums:

- › Each person on the policy has their own annual maximums.
- › Annual maximums reset every January.
- › You are entirely responsible for any charges that exceed your annual maximums.
- › Expenses applied toward the outpatient services will also be applied to, and reduce, your annual maximum amount.
- › Annual maximums are unique to this plan; HumanaOne offers other plans without an annual maximum.

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:
 - your payment toward the deductible is NOT credited to the deductible for network providers
 - your out-of-pocket costs are NOT credited to the out-of-pocket maximum for network providers
2. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
3. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
4. This is a combined maximum to include diagnostic lab/x-ray/interpretation, in a clinic or outpatient location.
5. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement. The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.
6. This value-added feature is not insurance. There is no coverage for retail and/or mail order prescription drugs unless stated in the policy.
7. 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.
8. This benefit also 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.
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

HumanaOne Short Term Medical plans

Short Term 100/75

These plans are available for a minimum of 30 days and maximum of six months

Pre-existing conditions are not covered under this plan

		Plan pays for services from NETWORK providers ⁷	Plan pays for services from NON-NETWORK providers ⁸
Deductible options¹ • per benefit period	• individual	\$1,000/\$2,500/\$5,000	\$2,000/\$5,000/\$10,000
	• family (two family members must each meet their individual deductible)	\$2,000/\$5,000/\$10,000	\$4,000/\$10,000/\$20,000
Coinsurance out-of-pocket limit¹ • per benefit period • deductibles do not apply	• individual	Not applicable	\$5,000
	• family	Not applicable	\$10,000
Preventive care	<ul style="list-style-type: none"> preventive office visits age 13 and over child immunizations age 13 to age 18 Pap smear and mammogram prostate screening preventive lab and X-ray 	Not covered	Not covered
	<ul style="list-style-type: none"> colorectal cancer screening (including exams and labs) child health supervision services birth to age 13 (includes exams, lab and immunizations) 	100%	75%
Physician services	<ul style="list-style-type: none"> office visits (including allergy injections) diagnostic lab and X-ray³ allergy testing allergy serum inpatient and outpatient services surgery 	100% after deductible	75% after deductible
Facility services	<ul style="list-style-type: none"> inpatient and outpatient services outpatient surgery newborn hospital stay⁵ emergency services 	100% after deductible	75% after deductible
Prescription drug⁴ • mail order not available	• deductible per individual	Integrated with medical	Integrated with medical
	• benefit per prescription or refill	100% after deductible	75% after deductible
Other medical services • prior authorization required in order to be eligible for these benefits	<ul style="list-style-type: none"> skilled nursing facility (up to 30 days per benefit period) home health care (up to 60 visits per benefit period) durable medical equipment pregnancy complications and sick baby services (no prior authorization required) hospice⁶ 	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	<ul style="list-style-type: none"> inpatient services outpatient and office therapy sessions 	Not covered	Not covered

Your policy is not renewable and does not include a 12-month rate guarantee.

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.

- When you obtain care from non-network providers:
 - your payment toward the deductible is NOT credited to the deductible for network providers
 - your out-of-pocket costs are NOT credited to the out-of-pocket maximum for network providers
- Only available for plans six months or less in duration.
- MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
- If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- 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.
- 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.
- 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.**
- 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.**

Short Term 80/60

Plan pays for services from NETWORK providers ⁷	Plan pays for services from NON-NETWORK providers ⁸
\$500/\$1,000/\$2,500/\$5,000	\$1,000/\$2,000/\$5,000/\$10,000
\$1,000/\$2,000/\$5,000/\$10,000	\$2,000/\$4,000/\$10,000/\$20,000
\$2,000	\$8,000
\$4,000	\$16,000
Not covered	Not covered
80%	60%
80% after deductible	60% after deductible
80% after deductible	60% after deductible
Integrated with medical	Integrated with medical
80% after deductible	60% after deductible
80% after deductible	60% after deductible
80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
\$2,000,000 per covered person	
Not covered	Not covered

HumanaOne's Short Term Medical plans can help protect you and your family if you find yourself without health insurance. You can choose the plan you need and have coverage for unexpected illness, injuries and accidents until you receive permanent coverage.

It's an ideal choice if you're:

- › a student or recent graduate
- › between jobs
- › waiting for employer benefits to begin
- › without coverage due to job or life changes
- › a part-time, temporary or seasonal employee
- › retired and waiting for Medicare eligibility

And the best part is that if you are eligible you can receive coverage as quickly as the day after applying. You don't have to wait weeks for the coverage you need today.

HumanaOne Individual Dental Insurance



Visit **MyDentalIQ.com** to find out how to improve your oral health. Following a few simple steps could possibly help lower your total healthcare costs over time.

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of more than 120,000 dentist locations in the PPO network. Visit **Humana.com** to find a dentist.

Annual deductible	\$50 individual / \$150 family	
Preventive services	<ul style="list-style-type: none"> oral examinations routine cleanings x-rays sealants topical fluoride treatment 	100% no deductible
Basic services	<ul style="list-style-type: none"> emergency care for pain relief thumb sucking and harmful habit appliances space maintainers amalgam, composite fillings (front/anterior teeth only) oral surgery routine extractions non-cast stainless steel crowns partial or complete denture repairs/adjustments 	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 		
Major services	<ul style="list-style-type: none"> endodontics (root canals) periodontics crowns inlays and onlays partial or complete dentures denture relines/rebases removable or fixed bridgework 	50% after deductible
<ul style="list-style-type: none"> twelve month waiting period applies 		
Teeth whitening	<ul style="list-style-type: none"> \$200 lifetime maximum 	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 		
Orthodontia	Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.	
Annual maximum	\$1,000 per covered person	

HumanaOne individual dental insurance is only available with a HumanaOne medical plan.

HumanaOne Individual Term Life Insurance

With HumanaOne term life, you can buy a higher amount of insurance protection at a lower cost. You own the policy and maintain control, providing more flexibility for your family.

Coverage amounts¹	<ul style="list-style-type: none">• Amounts start at \$25,000 and can go up to a maximum of \$150,000.
Term levels	<ul style="list-style-type: none">• Ages 18-65 for a 10-year level premium term• Ages 18-60 for a 15-year level premium term• Ages 18-55 for a 20-year level premium term
Rate guarantee	<ul style="list-style-type: none">• Rates are guaranteed for the full term of the policy
Renewals	<ul style="list-style-type: none">• HumanaOne Term Life Insurance is guaranteed renewable to age 95. Premiums after the initial level premium period will increase annually, but are also guaranteed.

¹ By applying for life insurance and health insurance simultaneously you will automatically be approved for up to \$150,000 in life insurance coverage if you are approved for health insurance coverage.

How much life insurance do you need?

One rule of thumb for recommended coverage is a life insurance amount equal to up to 10 times annual income, according to the American Council for Life Insurers. No one guideline applies to everyone, however, because financial situations and goals vary from person to person, and family to family.

To estimate the amount of life insurance you may need, you can use our online life insurance calculator at www.humana-one.com/life-insurance/term-life-insurance.asp and select "life insurance calculator."

Medical limitations and exclusions

This is an outline of the limitations and exclusions for HumanaOne individual health plans. 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 plan are two months to 64.5 years. The maximum age for a dependent child is 25 years if the child has the same legal residence as the policyholder or is dependent upon the policyholder.

Pre-existing conditions

A pre-existing condition is a sickness, bodily injury or pregnancy for which a covered person incurred charges, received medical treatment, consulted with a health care practitioner or took prescription drugs within the 12-month period before their 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 limitations for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

HIPAA eligibility

If you recently lost group coverage through your employer and you have a pre-existing medical condition, a short term plan may not be ideal for you. If you purchase a short term plan instead of electing COBRA, you'll become ineligible for other guarantee-issue plans that are available through your state.

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 bodily injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.

18. Nicotine habit or addiction; educational or vocational 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 non-medical 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. Bodily 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.

Additional expenses not covered in the following HumanaOne plans:

Autograph: Share 80 Plus Rx, Portrait: Share 80 Plus Rx Unlimited, Monogram: Total Plus Rx, and Autograph: Total Plus Rx / HSA

1. Any drug, medicine or device which is not FDA approved.
2. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
3. Medications, drugs or hormones to stimulate growth.
4. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
5. 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.
6. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
7. Drugs used in treatment of nail fungus.
8. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
9. Vitamins, dietary products and any other nonprescription supplements.
10. 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.

Additional expenses not covered in the following HumanaOne plans:

Autograph: Total / HSA

1. Mental health including mental disorders, alcohol and chemical dependency.
2. Spinal manipulations and spinal adjustment modalities.
3. Prescription drugs except drugs provided or administered while confined in a hospital or skilled nursing facility, by a home health agency, by a healthcare practitioner during an office visit, or as stated in the policy.
4. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.

Medical limitations and exclusions (continued)

Additional expenses not covered in the following HumanaOne plan:

Annual Max 75/55

1. Charges in excess of the maximum allowable fee or which exceed any benefit maximum, calendar year policy maximum or lifetime maximum.
2. Services provided by a Chiropractor, including but not limited to exams, x-rays, laboratory, spinal manipulations and spinal adjustment modalities.
3. Any drug, medicine or device which is not FDA approved.
4. Contraceptives, including oral and transdermal, whether medication or device.
5. Medications, drugs or hormones to stimulate growth.
6. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered bodily injury or sickness.
7. 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.
8. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
9. Drugs used in treatment of nail fungus.
10. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than 1 year from the date of the original order.
11. Vitamins, dietary products and any other non-prescription supplements.
12. Pregnancy and well-baby expenses, except as stated in the policy.
13. Dental services (except for dental injury), appliances or supplies, except as stated in the policy.
14. Any treatment for mental health, including but not limited to prescription drugs, except as stated in the policy.
15. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
16. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
3. Any treatment for mental health, including but not limited to prescription drugs, except as stated in the policy.
4. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
5. Prescription drugs except drugs provided or administered while confined in a hospital, skilled nursing facility, by a healthcare practitioner during an office visit or by a home healthcare agency.
6. Pregnancy and well-baby expenses, except as stated in the policy.
7. Dental services (except for dental injury), appliances or supplies, except as stated in the policy.
8. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.

Additional expenses not covered in the following HumanaOne plan:

Annual Max 50/30

1. Charges in excess of the maximum allowable fee or which exceed any benefit maximum, calendar year policy maximum or lifetime maximum.
2. Services provided by a Chiropractor, including but not limited to exams, X-rays, laboratory, spinal

Important information about Annual Max plans

This HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses applied to the outpatient and pharmacy calendar year limits will also be applied to the all covered services calendar year limit. Any costs incurred for services above the calendar year limits are the member's responsibility. Humana has other plans available that do not have calendar year limits, see your state-specific benefit summary for details.

Short Term Medical limitations and exclusions

This is an outline of the limitations and exclusions for HumanaOne Short Term Medical plans. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is not renewable.

Eligibility

The issue ages for HumanaOne individual health plans are 30 days to 64 years 11 months. The maximum age for a dependent child is 25 years if the child has the same legal residence as the policyholder or is financially dependent upon the policyholder.

Pre-existing Conditions

No benefits are payable for any pre-existing condition. A pre-existing condition exists if a covered person had a sickness, bodily injury or pregnancy for which they incurred charges, received medical treatment, consulted a healthcare practitioner, or took prescription drugs within 12 months prior to this policy's effective date.

HIPAA eligibility

If you recently lost group coverage through your employer and you have a pre-existing medical condition, a short term plan may not be ideal for you. If you purchase a short term plan instead of electing COBRA, you'll become ineligible for other guarantee-issue plans that are available through your state.

Other expenses not covered

Unless stated otherwise no benefits are payable for expenses arising from:

1. Conditions which first manifested during a prior Short Term Medical policy or certificate issued by us.
2. Services for a condition for which claims were submitted under a prior Short Term Medical policy or certificate issued by us.
3. Services not medically necessary or which are experimental, investigational or for research purposes.
4. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
5. 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.
6. Charges in excess of the maximum allowable fee or which exceed any benefit maximum.
7. Hospice services except as stated in the policy.
8. Expenses incurred before the effective date.
9. Expense incurred after the date coverage is terminated except as provided under the Extension of Benefits.
10. Cosmetic procedures and any related complications except as stated in the policy.
11. Custodial or maintenance care.
12. Preventive care service, except as stated in the policy.
13. Any drug, medicine or device which is not FDA approved.
14. Contraceptives, including oral and transdermal, whether medication or device.
15. Medications, drugs or hormones to stimulate growth.
16. Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
17. 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.
18. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
19. Drugs used in treatment of nail fungus.
20. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than 1 year from the date of the original order.
21. Vitamins, dietary products and any other non-prescription supplements.
22. Infertility services.
23. Pregnancy and well-baby expenses.
24. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
25. Vision therapy; all types of refractive keratoplastics or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses, hearing aids; dental exams.
26. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests except as stated in the policy.
27. Services received at an emergency room unless required because of emergency care.
28. Dental services (except for dental injury), appliances or supplies, except as stated in the policy.
29. War or any act of war, whether declared or not, commission or attempt to commit a civil or criminal battery or felony.
30. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation except as stated in the policy.
31. Any treatment for the purpose of reducing obesity or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by or exacerbated by obesity, including but not limited to surgical procedures.
32. Nicotine habit or addiction; educational or vocational 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.
33. Foot care services.
34. Any treatment for mental health, including but not limited to prescription drugs, except as stated in the policy.
35. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
36. 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.
37. Hair prosthesis; hair transplants or wigs.
38. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
39. Surgical treatment for hernia or removal of tonsils and/or adenoids unless the condition requires emergency care.
40. Surgical treatment for bunions, varicose veins or hemorrhoids.
41. Bodily injury or sickness arising out of the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation.
42. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
43. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
44. Charges covered by other medical payments insurance.
45. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
46. 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.

Extension of Benefits:

Extension of Benefits provision will apply (for no additional premium) with Short Term Medical plans under the following conditions:

1. You have met your deductible and are totally disabled, coverage for the disabling condition continues, but not beyond the earliest of the following dates: a) The date on which you are no longer continuously confined in a hospital; b) the date your provider certifies you are no longer totally disabled; c) the date your maximum benefit or your individual lifetime maximum is met; d) the last day of a 12 consecutive month period following the expiration of your plan; e) the earliest date permitted by law.
2. You have met your deductible and are being treated for complications of, or need follow-up treatment for, a sickness that commenced or a bodily injury sustained while the policy was in effect. A \$1,000 maximum benefit may be available for expenses incurred during a period of

not more than 60 days beyond the expiration date of coverage.

Dental limitations and exclusions

This is an outline of the limitations and exclusions for the HumanaOne individual dental plan. It is designed for convenient reference.

Consult the policy/certificate for a complete list of limitations and exclusions.

Unless stated otherwise, no benefits are payable for expenses arising from:

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government, unless legally required to pay.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy/certificate.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.

Payments (medical and dental)—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.

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, HumanaDental Insurance Company
Applications are subject to approval. Waiting periods, limitations and exclusions may 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.

CO-51530-HO 7/09

Policy numbers: GN-70129 8/2002, et al.; CO-70141-HD, et al.; GN-70136, et al.; GN-71007-01 1/2008, et al.; GN-71008-01 1/2008, et al.