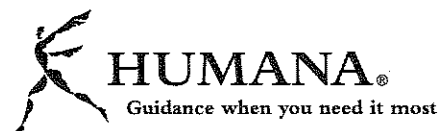


**Colorado Health Plan Description Form
Humana Insurance Company
Individual Health Plan**

PART A: TYPE OF COVERAGE

1. Type of plan	Preferred Provider Plan
2. Out-of-network care covered? (1)	Yes, but the patient pays more for out-of-network care
3. Areas of Colorado where plan is available	Plan is available throughout Colorado

Humana Insurance Company
Local Contact at Regional Office
8400 East Prentice Avenue, Suite 1400
Englewood, CO 80111-2926
Local: 303-694-1044
Toll-Free: 800-825-7496



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PART B: SUMMARY OF BENEFITS:

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

	IN-NETWORK		OUT-OF-NETWORK	
4. Annual deductible	Single \$ 500 1,000 2,500 5,000	Family \$ 1,500 3,000 5,000 10,000	Single \$1,000 2,000 5,000 10,000	Family \$ 3,000 6,000 10,000 20,000
5. Out-of-pocket annual maximum <i>(must be satisfied by each covered person, does not include deductible or copayment) (2)</i>	\$2,000		\$8,000	
6. Lifetime benefit maximum paid by the plan for all care	\$5,000,000 <i>(combined in and out of network)</i>			
7. a. Covered providers	ChoiceCare network See applicable provider directory for complete list of current providers.		All providers licensed or certified to provide covered benefits.	
7. b. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable		Not applicable	
8. Routine medical office visits	80% after deductible		60% after deductible	
9. Preventive care a. Children's services including exams and immunizations <i>(birth to age 13) (not subject to deductible)</i> b. Adult services 1. Colorectal screening <i>(not subject to deductible)</i> 2. Routine immunizations <i>(age 13 to 18) (payable after 90-day wait, up to a combined maximum of \$300 per person per calendar year)</i> 3. Annual routine Pap smear, annual routine physical exam <i>(age 13 and older) (payable after 90-day wait, up to a combined maximum</i>	80% 80% 80% 80%		60% 60% Not covered Not covered	

	IN-NETWORK	OUT-OF-NETWORK
<p><i>of \$300 per person per calendar year)</i></p> <p>4. Annual routine mammogram; PSA (<i>not subject to deductible</i>)</p> <p>5. Routine lab, pathology and X-ray (<i>payable after 90-day wait, up to a combined maximum of \$300 per person per calendar year</i>)</p>	<p>80%</p> <p>80% after deductible</p>	<p>60%</p> <p>Not covered</p>
<p>10. Maternity</p> <p>a. Prenatal care (<i>unless optional maternity rider is purchased</i>)</p> <p>b. Delivery (<i>unless optional maternity rider is purchased</i>)</p> <p>c. Inpatient wel-baby hospital services</p>	<p>Not covered</p> <p>Not covered</p> <p>80% after deductible</p>	<p>Not covered</p> <p>Not covered</p> <p>60% after deductible</p>
<p>11. Prescription drugs</p> <p>a. Separate annual deductible (<i>medical deductibles or out-of-pocket amounts do not apply</i>)</p> <p>b. Benefit for each prescription or refill (<i>up to 30-day supply</i>)</p> <p>- Level One</p> <p>- Level Two</p> <p>- Level Three</p> <p>- Level Four</p> <p>Mail order (<i>90-day supply</i>)</p>	<p>\$500 per individual</p> <p>100% after \$10 copayment after deductible</p> <p>\$30 copayment after deductible</p> <p>\$50 copayment after deductible</p> <p>25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year</p> <p>100% after three times the retail copayment</p>	<p>\$500 per individual</p> <p>70% after: \$10 copayment after deductible</p> <p>\$30 copayment after deductible</p> <p>\$50 copayment after deductible</p> <p>25% copayment after deductible up to \$2,500 maximum out-of-pocket per calendar year</p> <p>100% after three times the retail copayment</p>
<p>12. Inpatient Hospital</p>	<p>80% after deductible</p>	<p>60% after deductible</p>
<p>13. Outpatient Hospital/Ambulatory surgery</p> <p>a. Nonsurgical</p> <p>b. Surgical (<i>outpatient benefit payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and 180 day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia</i>) (<i>does not include</i></p>	<p>80% after deductible</p> <p>80% after deductible</p>	<p>60% after deductible</p> <p>60% after deductible</p>

	IN-NETWORK	OUT-OF-NETWORK
<i>strangulated or incarcerated hernia).</i>		
14. Laboratory and X-ray	80% after deductible	60% after deductible
15. Emergency room (<i>including physician visits</i>) (3)	80% after \$75 copayment per visit and deductible (<i>copayment waived if admitted</i>)	60% after \$75 copayment per visit and deductible (<i>copayment waived if admitted</i>)
16. Ambulance (<i>up to \$15,000 maximum per calendar year</i>)	80% after deductible	80% after deductible
17. Urgent, nonroutine after hours care	80% after deductible	60% after deductible
18. Biologically based mental illness (4)	Not applicable	Not applicable
19. Other mental health care (<i>benefits payable after one year waiting period</i>) a. Inpatient (<i>up to \$2,500 maximum per calendar year for all mental health benefits</i>) b. Outpatient therapy (<i>up to \$500 maximum per calendar year for all mental health benefits; Outpatient Mental Health maximum reduces Inpatient Mental Health maximum</i>)	50% after deductible 50% after deductible	50% after deductible 50% after deductible
20. Alcohol and substance abuse (<i>benefits payable after one year waiting period</i>) a. Inpatient (<i>up to \$2,500 maximum per calendar year for all mental health benefits</i>) b. Outpatient therapy (<i>up to \$500 maximum per calendar year for all mental health benefits</i>)	See #19, Other mental health care See #19, Other mental health care	See #19, Other mental health care See #19, Other mental health care
21. Physical/Chiropractic , occupational and speech therapy (<i>limited to a combined maximum of 20 visits per calendar year</i>)	80% after deductible	60% after deductible
22. Durable medical equipment (<i>preauthorization required</i>)	80% after deductible	60% after deductible

	IN-NETWORK	OUT-OF-NETWORK
23. Oxygen (<i>preauthorization required</i>)	80% after deductible	60% after deductible
24. Organ transplants (<i>preauthorization required</i>)	80% after deductible when services are at a National Transplant Network Provider	60% after deductible to separate out-of-pocket maximum of \$35,000 per calendar year
25. Home health care (<i>preauthorization required; limited to 60 visits per calendar year</i>)	80% after deductible	60% after deductible
26. Hospice care (<i>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</i>)	80% after deductible	60% after deductible
27. Skilled nursing facility care (<i>up to 30 days per calendar year</i>)	80% after deductible	60% after deductible
28. Dental care (<i>injury or outpatient hospital and anesthesia for a covered dependent</i>)	80% after deductible	60% after deductible
29. Vision care	No coverage	No coverage
30. Chiropractic care (<i>see 21 for visit limitation</i>)	80% after deductible	60% after deductible
31. Significant additional covered services – Cleft lip and palate – Diabetes	80% after deductible	80% after deductible

PART C: LIMITATIONS AND EXCLUSIONS

32. Period during which pre-existing conditions are not covered (5)	Twelve months for all pre-existing conditions unless the covered person is a HIPAA eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33. Exclusionary riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA eligible individual as defined under federal and state law.
34. How does the policy define a "pre-existing condition"?	A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.

35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.
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PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main Customer Service number?	1-800-833-6917	
40. Whom do I write/call if I have a complaint or want to file a grievance? (6)	Write to: Humana Grievance & Appeals Office P.O. Box 14616 Lexington, KY 40512-4616 Phone: 1-800-833-6317	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy, whether it is individual small group or large group, and if it is a short-term policy.	Policy form # GN-70129 et al, individual	

PART E: COST

43. What is the cost of this plan?	Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.
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PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?