HumanaOne®
Short Term Medical 100/75

Colorado

About your plan

HumanaOne Short Term Medical plans: Right plan, right time

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. This plan is available for a minimum of 30 days and a maximum of six months.

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

HumanaOne Short Term Medical plans offer:

- **Coverage you need:**
  All of HumanaOne's Short Term Medical plans include coverage for doctor office visits (for illness and injury), inpatient and outpatient procedures, emergency services, and prescription drugs.
- **Coverage when you need it:**
  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.
- **Choice of deductibles:**
  We offer a range of deductibles on our Short Term Medical plans to ensure you get the coverage you need at a price you can afford.
- **Network savings:**
  With these short term plans, you have access to a large network of doctors, whether you are at home or traveling. It's likely the physicians you currently use are already among our network providers. Keep in mind that you'll receive the most savings when visiting network providers, but you're still covered for most services if you choose to visit a non-network provider.
- **Service you can rely on:**
  You will be well-taken care of at HumanaOne. Every step of the way has been designed to provide you with a simple and hassle-free experience.

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How your plan works

The details below give you a general idea of covered benefits for this plan and don't explain everything. To be covered, expenses must be medically necessary and listed as covered in the plan policy. The plan policy is a document which outlines the benefits, provisions, and limitations of the plan. Please refer to a policy for this plan for the actual terms and conditions of the plan. This plan also has limitations and services that are not covered. You should know about these. See page 4 for details.

	IN-NETWORK		OUT-OF-NETWORK	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay	Individual:	Family:	Individual:	Family:
Important to know:	$1,000	$2,000	$2,000	$4,000
› Deductibles are per benefit period	$2,500	$5,000	$5,000	$10,000
› Once two family members meet their individual deductible, the family deductible will be met for all other family members	$5,000	$10,000	$10,000	$20,000
› Your payment toward your out-of-network deductible is not credited to your in-network deductible				
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	Your plan pays 100% of covered expenses after you pay your deductible		You pay 25% of covered expenses after you pay your deductible	
Your out-of-pocket maximum – The amount you're required to pay toward the covered cost of your healthcare; premium, and deductibles don't apply	Not applicable	Not applicable	$5,000	$10,000
Important to know:				
› Out-of-pocket maximum is per benefit period				
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	$2,000,000 per covered person			

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	IN-NETWORK	OUT-OF-NETWORK
Preventive care – preventive office visits (age 13 and over), preventive lab (age 13 and over) (except as listed), preventive X-ray	Not covered	Not covered
› Child health supervision services birth to age 13 (includes exams and labs)	Your plan pays 100%	You pay 25% after you pay your deductible
› Child immunizations (birth to age 18), Pap smear and mammogram , colorectal cancer screening (including exam and lab tests), cholesterol screening for lipid disorders, prostate screening and digital rectal exam	Your plan pays 100%	Your plan pays 100%
Physician services – includes: office visits (including allergy injections), diagnostic lab and X-ray, allergy testing, allergy serum, inpatient and outpatient services and surgery	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Inpatient hospital and outpatient services	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Emergency services	Your plan pays 100% after you pay your deductible	Your plan pays 100% after you pay your deductible
Mental health (mental illness and chemical dependency) – excludes treatment for alcohol misuse, age 18 and older		
› inpatient services	Not covered	Not covered
› outpatient and office therapy sessions		
Mental health (alcohol misuse behavior counseling intervention, age 18 and older) – excludes treatment for mental illness and chemical dependency		
› inpatient services	Your plan pays 100% after you pay your deductible	Your plan pays 75% after you pay your deductible
› outpatient and office therapy sessions		
Other medical services		
› Skilled nursing facility (up to 30 days per benefit period)	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
› Home health care (up to 60 visits per benefit period)		
› Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy, spinal manipulations, adjustments, and modalities - (combined, up to 10 visits per benefit period)		
› Hospice (Bereavement limited to $1,400 per family for the 12-month period following death. Nursing, social/counseling services, and certified nurses aid or delegated nursing services, limited to $13,650 per member per benefit period.)		
› Transplant services	Your plan pays 100% after you pay your deductible when you receive services from a Humana Transplant Network provider	You pay 25% after you pay your deductible. Plan pays up to $35,000 per transplant

	IN-NETWORK	OUT-OF-NETWORK
Prescription drug		
Important to know: › Mail order is not available › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › Prescription drug deductible is integrated with your medical deductible and out-of-pocket maximum	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible

Network agreement

Network providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible or coinsurance. 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.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the HumanaOne plan listed above. 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. A dependent child must be less than 26 years of age to apply.

Pre-existing conditions

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 health care practitioner, or took prescription drugs within 12 months prior to this policy's effective date. No benefits are payable for any pre-existing condition.

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 issued by us.
2. Services for a condition for which claims were submitted under a prior Short Term Medical policy 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 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. Medications, drugs or hormones to stimulate growth.
15. Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
16. 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.
17. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
18. Drugs used in treatment of nail fungus.
19. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
20. Vitamins, dietary products and any other non-prescription supplements.
21. Infertility services including medications.
22. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
23. Vision therapy; all types of refractive keratoplastics or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids, unless otherwise indicated in this policy; dental exams.
24. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests, except as stated in the policy.
25. Services received at an emergency room unless required because of emergency care.
26. Dental services (except for dental injury or cleft lip or cleft palate), appliances or supplies.
27. War or any act of war, whether declared or not, commission or attempt to commit a civil or criminal battery or felony.
28. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation except as stated in the policy.
29. 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.

30. 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.
31. Foot care services.
32. Any treatment for mental health including but not limited to prescription drugs, except as stated in the policy.
33. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
34. 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.
35. Hair prosthesis, hair transplants or wigs.
36. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
37. Surgical treatment for hernia or removal of tonsils and/or adenoids unless the condition requires emergency care.
38. Surgical treatment for bunions, varicose veins or hemorrhoids.
39. Bodily injury and 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.
40. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
41. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
42. Charges covered by other medical payments insurance.
43. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
44. 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.
45. Treatment for complications of non-covered procedure or service.

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 any 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.

Colorado law required carriers to make available a Colorado Health Plan Description From, 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 require, 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
Applications are subject to approval. Limitations and exclusions apply.

This document contains a general summary of covered 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.

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