



HUMANA SIMPLICITY

PPO, NPOS, and HMO PLANS – For in-network healthcare services, there is no deductible. In-network preventive services, such as annual exams, are covered at 100%. For other covered services, members pay only a copay when in-network providers are used. All copays, including prescription drugs, count toward the maximum out-of-pocket.

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance		Deductible ¹	Maximum out-of-pocket		Copay amounts:				
		In	Out		Individual	Family	Primary care/ Specialist	Telemedicine/Retail clinic/ Urgent care/ER	Advanced imaging	Inpatient ² / Outpatient services	Pharmacy
1	Gold	100%	50%	\$0	\$4,500	\$9,000	\$40/\$75	\$20/\$40/\$100/\$350	\$350	\$750/\$750	\$10/\$35/\$55/25%
2	Gold	100%	50%	\$0	\$6,000	\$12,000	\$40/\$75	\$20/\$40/\$100/\$400	\$400	\$1,000/\$1,000	\$10/\$35/\$55/25%
3	Gold	100%	50%	\$0	\$6,000	\$12,000	\$40/\$80	\$20/\$40/\$100/\$400	\$400	\$1,250/\$1,250	\$10/\$40/\$75/25%
4	Gold	100%	50%	\$0	\$6,000	\$12,000	\$40/\$80	\$20/\$40/\$100/\$425	\$425	\$1,500/\$1,500	\$10/\$40/\$75/25%
5	Gold	100%	50%	\$0	\$6,000	\$12,000	\$40/\$80	\$20/\$40/\$100/\$450	\$450	\$1,750/\$1,750	\$10/\$40/\$75/25%
6	Gold	100%	50%	\$0	\$7,350	\$14,700	\$40/\$80	\$20/\$40/\$100/\$500	\$500	\$2,000/\$2,000	\$10/\$45/\$90/25%

(1) \$5,000 individual / \$10,000 family out-of-network deductible

(2) Copay per day for first three days



TRADITIONAL PLANS: COPAY

PPO, NPOS, and HMO PLANS – In-network preventive services, such as annual exams, are covered at 100%. For other covered services, members pay only copay or deductible / coinsurance when in-network providers are used. Deductible, coinsurance and/or copays, including prescription drugs, count toward the maximum out-of-pocket.

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance		Deductible		Maximum out-of-pocket		Primary care / Specialist	Telemedicine/ Retail clinic / Urgent care / ER	Pharmacy	Other services
		In	Out	Individual	Family	Individual	Family				
1 ¹	Platinum	100%	70%	\$1,000	\$2,000	\$3,500	\$7,000	\$20/\$40	\$20/\$40/\$100/\$350	\$10/\$35/\$55/25%	Coinsurance after deductible
2	Gold	100%	70%	\$1,500	\$3,000	\$5,000	\$10,000	\$35/\$65	\$20/\$40/\$100/\$500	\$10/\$40/\$75/25%	Coinsurance after deductible
3	Gold	100%	70%	\$2,000	\$4,000	\$5,500	\$11,000	\$35/\$65	\$20/\$40/\$100/\$500	\$10/\$40/\$75/25%	Coinsurance after deductible
4	Gold	100%	70%	\$2,500	\$5,000	\$6,000	\$12,000	\$35/\$65	\$20/\$40/\$100/\$450	\$10/\$40/\$75/25%	Coinsurance after deductible
5	Gold	100%	70%	\$3,000	\$6,000	\$5,000	\$10,000	\$35/\$65	\$20/\$40/\$100/\$400	\$10/\$40/\$75/25%	Coinsurance after deductible
6	Gold	100%	70%	\$4,500	\$9,000	\$5,500	\$11,000	\$30/\$65	\$20/\$40/\$100/\$450	\$10/\$35/\$55/25%	Coinsurance after deductible
7 ¹	Silver	100%	70%	\$6,500	\$13,000	\$7,350	\$14,700	\$45/\$90	\$20/\$40/\$100/\$600	\$10/\$45/\$90/25%	Coinsurance after deductible
8	Gold	80%	50%	\$1,000	\$2,000	\$4,500	\$9,000	\$30/\$60	\$20/\$40/\$100/\$450	\$10/\$40/\$75/25%	Coinsurance after deductible
9 ¹	Gold	80%	50%	\$1,500	\$3,000	\$4,500	\$9,000	\$30/\$60	\$20/\$40/\$100/\$400	\$10/\$40/\$75/25%	Coinsurance after deductible
10	Gold	80%	50%	\$2,000	\$4,000	\$5,000	\$10,000	\$30/\$60	\$20/\$40/\$100/\$400	\$10/\$35/\$55/25%	Coinsurance after deductible
11 ¹	Gold	80%	50%	\$2,000	\$4,000	\$6,500	\$13,000	\$30/\$60	\$20/\$40/\$100/\$500	\$10/\$40/\$75/25%	Coinsurance after deductible
12	Gold	80%	50%	\$2,500	\$5,000	\$5,500	\$11,000	\$35/\$70	\$20/\$40/\$100/\$550	\$10/\$40/\$75/25%	Coinsurance after deductible
13 ¹	Silver	80%	50%	\$3,500	\$7,000	\$7,000	\$14,000	\$45/\$90	\$20/\$40/\$100/\$450	\$10/\$45/\$90/25% ²	Coinsurance after deductible
14 ¹	Silver	80%	50%	\$5,000	\$10,000	\$7,350	\$14,700	\$45/\$90	\$20/\$40/\$100/\$550	\$10/\$45/\$90/25%	Coinsurance after deductible
15 ¹	Gold	70%	50%	\$2,000	\$4,000	\$6,000	\$12,000	\$30/\$60	\$20/\$40/\$100/\$500	\$10/\$40/\$75/25%	Coinsurance after deductible
16	Silver	70%	50%	\$3,500	\$7,000	\$7,350	\$14,700	\$45/\$90	\$20/\$40/\$100/\$550	\$10/\$50/\$100/25%	Coinsurance after deductible
17	Silver	50%	50%	\$2,000	\$4,000	\$7,350	\$14,700	\$45/\$90	\$20/\$40/\$100/\$500	\$10/\$50/\$100/25%	Coinsurance after deductible
18 ¹	Silver	50%	50%	\$3,000	\$6,000	\$7,350	\$14,700	\$40/\$80	\$20/\$40/\$100/\$500	\$10/\$40/\$75/25%	Coinsurance after deductible
19	Silver	50%	50%	\$4,000	\$8,000	\$7,350	\$14,700	\$45/\$90	\$20/\$40/\$100/\$500	\$10/\$45/\$90/25%	Coinsurance after deductible
20 ¹	Silver	50%	50%	\$5,000	\$10,000	\$7,350	\$14,700	\$35/\$70	\$20/\$40/\$100/\$550	\$5/\$20/\$50/\$100/\$500	Coinsurance after deductible

(1) HMO Select network available with these options

(2) \$250 individual / \$500 family pharmacy deductible – applies to levels 2, 3, and 4 only

Note: Refer to page 5 for IL Coordinated Care HMO plan options



TRADITIONAL PLANS: CANOPY

NPOS PLANS – In-network preventive services, such as annual exams, are covered at 100%. For other covered services, members pay only copay or deductible / coinsurance when in-network providers are used. Deductible, coinsurance and/or copays, including prescription drugs, count toward the maximum out-of-pocket.

Plan features to understand:

- Members pay only a copay for primary care office exam, specialist office exam, telemedicine, retail clinic, urgent care, and pharmacy services
- All other services pay deductible/coinsurance including any lab or x-ray done in conjunction with an office visit

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance		Deductible		Maximum out-of-pocket		Primary care / Specialist	Telemedicine/ Retail clinic / Urgent care	Pharmacy	Other services including emergency room
		In	Out	Individual	Family	Individual	Family				
1	Silver	100%	70%	\$6,500	\$13,000	\$7,350	\$14,700	\$20/\$80	\$20/\$20/\$100	\$10/\$40/\$75/25% ¹	Coinsurance after deductible
2	Silver	100%	70%	\$6,500	\$13,000	\$7,350	\$14,700	\$20/\$80	\$20/\$20/\$100	\$5/\$20/\$50/\$100/\$500	Coinsurance after deductible
3	Silver	80%	50%	\$6,000	\$12,000	\$7,350	\$14,700	\$20/\$80	\$20/\$20/\$100	\$10/\$40/\$75/25%	Coinsurance after deductible
4	Silver	80%	50%	\$6,000	\$12,000	\$7,350	\$14,700	\$20/\$80	\$20/\$20/\$100	\$5/\$20/\$50/\$100/\$500	Coinsurance after deductible

(1) \$250 individual / \$500 family pharmacy deductible – applies to levels 2, 3, and 4 only



HDHP PLANS

PPO, NPOS, and HMO PLANS – HDHP, or High Deductible Health Plans, feature budget-friendly premiums and pay coinsurance benefits after the deductible is met for all covered services. Plan includes coverage for preventive services, such as annual exams, at 100% when in-network providers are used. HDHPs are also compatible with health savings accounts (HSAs).

AGGREGATE – All covered benefits apply to the family deductible and family maximum out-of-pocket. The plan pays a coinsurance percentage after the entire family deductible is met.

If you use IN-NETWORK providers

Option	Metallic tier	Coinsurance		Deductible		Maximum out-of-pocket				Pharmacy	Other services
		In	Out	Individual	Family	In-network		Out-of-network			
				Individual	Family	Individual	Family	Individual	Family		
1	Silver	100%	70%	\$3,675	\$7,350	\$3,675	\$7,350	\$15,000	\$30,000	Coinsurance after deductible	Coinsurance after deductible

EMBEDDED – All covered benefits apply to the individual and family deductible and maximum out-of-pocket. When any family member reaches the individual deductible amount, that family member will begin receiving coinsurance benefits – even if the family deductible has not been met.

If you use IN-NETWORK providers

Option	Metallic tier	Coinsurance		Deductible		Maximum out-of-pocket				Pharmacy	Other services
		In	Out	Individual	Family	In-network		Out-of-network			
				Individual	Family	Individual	Family	Individual	Family		
1	Gold	100%	70%	\$2,700	\$5,400	\$2,700	\$5,400	\$9,000	\$18,000	Coinsurance after deductible	Coinsurance after deductible
2	Silver	100%	70%	\$4,000	\$8,000	\$4,000	\$8,000	\$15,000	\$30,000	Coinsurance after deductible	Coinsurance after deductible
3	Bronze	100%	70%	\$6,500	\$13,000	\$6,500	\$13,000	\$20,000	\$40,000	Coinsurance after deductible	Coinsurance after deductible
4	Silver	80%	50%	\$3,000	\$6,000	\$5,000	\$10,000	\$15,000	\$30,000	Coinsurance after deductible	Coinsurance after deductible
5	Bronze	80%	50%	\$5,500	\$11,000	\$6,550	\$13,100	\$19,650	\$39,300	Coinsurance after deductible	Coinsurance after deductible
6	Bronze	70%	50%	\$5,500	\$11,000	\$6,550	\$13,100	\$19,650	\$39,300	Coinsurance after deductible	Coinsurance after deductible

Note: Refer to page 5 for IL Coordinated Care HMO plan options



ILLINOIS COORDINATED CARE NETWORK HMO PLANS

- When selecting the CCN Network, a group must include all 7 networks listed below for each plan option.
- Families will have to select one of the available Providers Systems through which they will receive care for the plan year.
- Preventive medical services are covered 100 percent.
- Plans include embedded pediatric dental and vision benefits.

Quote & Enroll all 7 Plans/Networks

The CCN Network includes the following provider systems:

Network Name	Provider System	County Location of Participating Providers	Example
Advocate CCN HMO	Advocate Health Care	Cook, DuPage, Kane, Lake Will	Simplicity Opt 105 – Advocate
Loyola CCN HMO	Loyola University Health Systems	Cook	Simplicity Opt 102 – Loyola
NorthShore CCN HMO	NorthShore University Health Systems	Cook, Kane	Simplicity Opt 106 – NorthShore
Northwest Community CCN HMO	Northwest Community Health Systems	Cook	Simplicity Opt 104 – Northwest
Presence CCN HMO	Presence Health System	Cook, Kane, Kankakee, Will	Simplicity Opt 101 – Presence
Sinai Health CCN HMO	Sinai Health System	Cook	Simplicity Opt 107 – Sinai
Swedish Covenant CCN HMO	Swedish Covenant Hospital	Cook	Simplicity Opt 103 – Swedish

HUMANA HMO SIMPLICITY PLANS

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance In	Deductible ¹		Maximum out-of-pocket		Primary care/ Specialist	Telemedicine/Retail clinic/ Urgent care/ER	Advanced imaging	Inpatient ² / Outpatient services	Pharmacy
			Individual	Family	Individual	Family					
101-107	Gold	100%	\$0		\$4,500	\$9,000	\$40/\$75	\$20/\$40/\$100/\$350	\$350	\$750/\$750	\$10/\$35/\$55/25%
108-114	Gold	100%	\$0		\$6,000	\$12,000	\$40/\$75	\$20/\$40/\$100/\$400	\$400	\$1,000/\$1,000	\$10/\$35/\$55/25%
115-121	Gold	100%	\$0		\$6,000	\$12,000	\$40/\$80	\$20/\$40/\$100/\$400	\$400	\$1,250/\$1,250	\$10/\$40/\$75/25%
122-128	Gold	100%	\$0		\$6,000	\$12,000	\$40/\$80	\$20/\$40/\$100/\$450	\$450	\$1,750/\$1,750	\$10/\$40/\$75/25%
129-135	Gold	100%	\$0		\$7,350	\$14,700	\$40/\$80	\$20/\$40/\$100/\$500	\$500	\$2,000/\$2,000	\$10/\$45/\$90/25%

HUMANA HMO Copay PLANS

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance In	Deductible		Maximum out-of-pocket		Primary care/ Specialist	Telemedicine/Retail clinic/ Urgent care/ER	Inpatient/ Outpatient services	Pharmacy	Other Services
			Individual	Family	Individual	Family					
143-149	Gold	100%	\$1,500	\$3,000	\$5,000	\$10,000	\$35/\$65	\$20/\$40/\$100/\$500	\$750/\$750	\$10/\$35/\$55/25%	Coinurance after deductible

HUMANA HMO EHDHP PLANS

If you use IN-NETWORK providers

Copay amounts:

Option	Metallic tier	Coinsurance In	Deductible		Maximum out-of-pocket		Pharmacy	Other Services
			Individual	Family	Individual	Family		
136-142	Gold	100%	\$6,500	\$13,000	\$6,500	\$13,000	Coinurance after deductible	Coinurance after deductible

(1) \$5,000 individual / \$10,000 family out-of-network deductible

(2) Copay per day for first three days



CHOOSE YOUR MEDICAL NETWORK

You can offer your employees a national network of providers or save with a Focused Provider Network that typically includes one or two local and well-known healthcare systems. (Available for all plan options).

PPO Plans:

- **Humana ChoiceCare Network® (CHC)** is one of the largest, most cost-effective physician and hospital network in the nation. Members can visit any participating network provider at any time.
- **ChoicePOS Network** enables Humana to offer flexible benefits while accessing the best provider discounts available. Members can visit any participating network provider at any time and do not need to choose a primary care physician.

NPOS Plans:

- **Humana National POS – Open Access Network** offers the advantages of an HMO with the flexibility of a PPO plan. Members can visit any participating network provider at any time and any location, and do not need to choose a primary care physician.

HMO Plans:

- **HMO Select** is a local HMO network close to home. Staying within a limited set of local physicians and other healthcare providers lowers the cost of health benefits. Members must choose a primary care physician and there are no out-of-network, non-emergency benefits.
- **Illinois Coordinated Care Network** is a focused network close to home. Staying within a limited set of local physicians and other healthcare providers lowers the cost of health benefits. Members must choose a primary care physician within the provider system they chose and have the freedom to visit specialists without referral from their primary care physician within that system as needed. There are no out-of-network, non-emergency benefits.

Pharmacy:

- **National Pharmacy Network:** With more than 64,000 pharmacies across the country, the network includes all national chains, major regional chains, and more than 25,000 independent pharmacies, along with Humana's mail delivery and specialty pharmacies.



TRADITIONAL PREFERRED

Flexible plan with low deductibles and ability to see any dentist. However, when members see a dentist in the Humana Dental PPO network, they benefit from the negotiated rates from in-network dentists.

Calendar-year maximum	\$1,000 / \$1,500 / \$2,000 / Unlimited		
Extended annual maximum	Receive 30% coinsurance for the rest of the year after you reach your annual maximum (orthodontia excluded). Does not apply to unlimited annual maximum.		
Calendar-year deductible¹	Option 1	Option 2	Option 3
Individual / Family	\$25/\$75	\$50/\$150	N/A
Coinsurance	Option 1	Option 2	Option 3
Preventive services	100%	100%	100%
Basic services	90%	80%	50%
Major services	60%	50%	50%

Funding options² (available for 2+ size groups):

- Employer-sponsored (50% participation required)
- Voluntary
- Administrative Services Only (ASO)

Enrollment options³ (available for 2+ size groups):

- **Open enrollment:** Employees without a qualifying event can only join during the annual open enrollment period (waiting periods may apply)
- **Late applicants:** Employees can join at any time during the plan year with or without a qualifying event. (Waiting periods apply)

Buy-up options	For 2+ size groups
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum
Periodontics in Basic services	Moves Periodontic services to Basic services coinsurance amount
Endodontics in Basic services	Moves Endodontic services to Basic services coinsurance amount
Composite fillings for molars	Covers composite fillings on molar teeth at Basic services coinsurance amount
Orthodontia ⁴	Choose: Child OR Adult/Child Pays 50% (no deductible) for orthodontia services up to a lifetime maximum (choose one): \$1,000 / \$1,500 / \$2,000

Buy-up options	For 10+ size groups
Implant placement and services ⁵	Covers implant placement and implant crowns, bridges, and dentures at Major services coinsurance amount. Limited to one tooth every five years (including implant crowns, bridges, and dentures)

- (1) Deductible does not apply to Preventive services
- (2) Multiple product options may be offered for groups of 5+
- (3) If you don't choose an option, open enrollment will apply
- (4) If you don't choose orthodontia, members may get a discount on non-covered services up to 20% if available through their dentist
- (5) Implant placement limited to one per tooth every five years including implant crowns, bridges, and dentures



PPO

In-network dentists provide dental services at a reduced rate. Members have higher out-of-pocket costs for services received from out-of-network dentists.

	In- and Out-of-network					
Calendar-year maximum	\$1,000 / \$1,500 / \$2,000 / Unlimited					
Extended annual maximum	Receive 30% coinsurance for the rest of the year after you reach your annual maximum (orthodontia excluded). Does not apply to unlimited annual maximum.					
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar-year deductible¹	Option 1		Option 2		Option 3	
Individual / Family	\$25/\$75	\$50/\$150	\$50/\$150	\$50/\$150	\$50/\$150	\$100/\$300
Coinsurance	Option 1		Option 2		Option 3	
Preventive services	100%	100%	100%	100%	100%	80%
Basic services	100%	80%	90%	80%	80%	50%
Major services	60%	50%	60%	50%	50%	50%

Funding options² (available for 2+ size groups):

- Employer-sponsored (50% participation required)
- Voluntary
- Administrative Services Only (ASO)

Enrollment options³ (available for 2+ size groups):

- **Open enrollment:** Employees without a qualifying event can only join during the annual open enrollment period (waiting periods may apply)
- **Late applicants:** Employees can join at any time during the plan year with or without a qualifying event. (Waiting periods apply)

Buy-up options	For 2+ size groups
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum
Periodontics in Basic services	Moves Periodontic services to Basic services coinsurance amount
Endodontics in Basic services	Moves Endodontic services to Basic services coinsurance amount
Composite fillings for molars	Covers composite fillings on molar teeth at Basic services coinsurance amount
Orthodontia ⁴	Choose: Child OR Adult/Child Pays 50% (no deductible) for orthodontia services up to a lifetime maximum (choose one): \$1,000 / \$1,500 / \$2,000
Buy-up options	For 10+ size groups
Implant placement and services ⁵	Covers implant placement and implant crowns, bridges, and dentures at Major services coinsurance amount. Limited to one tooth every five years (including implant crowns, bridges, and dentures)

- (1) Deductible does not apply to Preventive services
- (2) Multiple product options may be offered for groups of 5+
- (3) If you don't choose an option, open enrollment will apply
- (4) If you don't choose orthodontia, members may get a discount on non-covered services up to 20% if available through their dentist
- (5) Implant placement limited to one per tooth every five years including implant crowns, bridges, and dentures

PREVENTIVE PLUS

Covers commonly used preventive and basic services, including exams, X-rays, cleanings and fillings. Plus, discounts may be available on additional services like crowns, inlays, oral surgery and orthodontia.

Calendar-year maximum Individual / Family	\$1,000	
Calendar-year deductible¹ Individual / Family	\$50 / \$150	
Coinsurance	Option 1	Option 2
Preventive services	100%	100%
Basic services (Emergency care, fillings, & simple extractions)	80%	50%
Discount services: Not covered, but may be available at a discount through their dentist		
<ul style="list-style-type: none"> • Additional basic services (crowns, harmful habit appliances for children, oral surgery) • Major services • Orthodontia services 		
Buy-up options	For 2+ size groups	
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum	
Composite fillings for molars	Covers composite fillings on molar teeth at Basic services coinsurance amount	

(1) Deductible does not apply to Preventive services

(2) Multiple product options may be offered for groups of 5+

(3) If you don't choose an option, open enrollment will apply

Funding options² (available for 2+ size groups):

- Employer-sponsored (50% participation required)
- Voluntary
- Administrative Services Only (ASO)

Enrollment options³ (available for 2+ size groups):

- **Open enrollment:** Employees without a qualifying event can only join during the annual open enrollment period (waiting periods may apply)
- **Late applicants:** Employees can join at any time during the plan year with or without a qualifying event. (Waiting periods apply)

DHMO

Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet, and no waiting periods.

Member costs listed are for services provided by a chosen participating primary care dentist (PCD) only. A PCD may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services (applicable to HS plans): Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist.

Summary of services: Below is a sampling of the most frequently used dental service codes for these plans. For a complete listing of covered services and copays, please see individual plan summaries for each plan option.

ADA CODE	DESCRIPTION	HD205/HS205	HD210/HS210	HD215/HS215
Preventive services				
0120	Periodic oral evaluation	\$0	\$0	\$0
0210	X-Rays – complete series of radiographic images (including bitewing)	\$0	\$0	\$0
1110	Cleaning – adult / child	\$0	\$0	\$0
1206	Topical application of fluoride varnish; therapeutic application for moderate to high caries risk patients	\$0	\$0	\$0
1351	Sealant – per tooth	\$10	\$15	\$20
Basic services				
2140	Amalgam – one surface, primary or permanent	\$5	\$20	\$30
2330	Resin-based composite – one surface, anterior	\$30	\$35	\$45
2391	Resin-based composite – one surface, posterior	\$45	\$55	\$70
Major services				
2750	Crown – porcelain fused to high noble metal	\$270	\$350	\$410
3330	Molar root canal (permanent tooth); excluding final restoration	\$250	\$310	\$390
4910	Periodontal maintenance	\$45	\$55	\$70
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$0	\$40	\$55
7210	Surgical removal of erupted tooth – removal of bone and/or section of tooth	\$40	\$55	\$60
Orthodontics				
8070 / 8080	Up to 24 months of routine orthodontic treatment for Class I and Class II cases; children up to 19 years / adults 19 years and older	\$1,900 \$1,900	\$1,900 \$1,900	\$1,900 \$1,900

ELIGIBILITY

Traditional Preferred, PPO, Preventive Plus, and DHMO (2+ eligible employees)

Contribution	Participation
Employer-sponsored: employer pays 100% of premium	100%
Employer-sponsored: employers pays <100% of premium	50% or greater
Voluntary: employer pays <100% of premium	Less than 50%

WAITING PERIODS

Traditional Preferred, PPO, and Preventive Plus

- Most services in your plan are reimbursed as of the effective date
- No waiting periods for preventive services
- No waiting periods for endodontics or periodontics except for late applicants
- In some circumstances, benefits are available as 12 or 24 months of continual enrollment:

Contribution	Group size	Preventive	Basic	Major ¹	Orthodontia ¹
Initial enrollment, open enrollment & timely add-on	2-9 enrolled	No	No	12 months ²	24 months ²
	10 or more enrolled	No	No	No	12 months ² (no waiting period for employer sponsored)
Late applicant ³	2-9 enrolled	No	12 months	12 months	24 months

(1) Preventive Plus does not cover major and orthodontia services

(2) The 12-month waiting period may be decreased or waived based on the number of months the member had dental coverage immediately before joining the Humana Dental plan. Members must have prior orthodontia coverage to reduce or waive the waiting period under orthodontia

(3) Late applicant is not allowed with the open enrollment option

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Routine eye exam								
With dilation ¹	\$10	Up to \$30	\$10	Up to \$30	\$10	Up to \$30	\$0	Up to \$30
Retinal imaging ²	Up to \$39	Not covered	Up to \$39	Not covered	Up to \$39	No covered	Up to \$39	Not covered
Contact lens exam³								
Standard contact lens fit and follow-up	Up to \$55	Not covered	Up to \$55	Not covered	\$0	Up to \$30	\$0	Up to \$30
Premium contact lens fit and follow-up	10% off retail	Not covered	10% off retail	Not covered	10% off retail less \$55 allowance	Up to \$30	10% off retail less \$55 allowance	Up to \$30
Diabetic eye care¹ (care & testing for diabetic members; up to two services per year for each listed service)								
Exam	\$0	Up to \$77	\$0	Up to \$77	\$0	Up to \$77	\$0	Up to \$77
Retinal imaging	\$0	Up to \$50	\$0	Up to \$50	\$0	Up to \$50	\$0	Up to \$50
Extended ophthalmoscopy	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15
Gonioscopy	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15	\$0	Up to \$15
Scanning laser	\$0	Up to \$33	\$0	Up to \$33	\$0	Up to \$33	\$0	Up to \$33
Frames⁵								
Discounts may be available on all frames except when prohibited by the manufacturer	\$100 allowance 20% off balance over \$100	\$50 allowance	\$130 allowance 20% off balance over \$130	\$65 allowance	\$160 allowance 20% off balance over \$160	\$80 allowance	\$200 allowance 20% off balance over \$200	\$100 allowance
Standard plastic lenses⁴								
Single vision	\$25	Up to \$25	\$15	Up to \$25	\$10	Up to \$25	\$0	Up to \$25
Bifocal	\$25	Up to \$40	\$15	Up to \$40	\$10	Up to \$40	\$0	Up to \$40
Trifocal	\$25	Up to \$60	\$15	Up to \$60	\$10	Up to \$60	\$0	Up to \$60
Lenticular	\$25	Up to \$100	\$15	Up to \$100	\$10	Up to \$100	\$0	Up to \$100

(1) Not covered on Materials Only 130 and 160

(2) Member costs may exceed \$39 with certain providers.

(3) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.

(4) Lens option costs may vary by provider.

(5) Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Lens options⁴								
UV coating	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Tint (solid & gradient)	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Standard scratch-resistance	\$15	Not covered	\$15	Not covered	\$15	Not covered	\$15	Not covered
Standard polycarbonate	\$40	Not covered	\$40	Not covered	\$40	Not covered	\$40	Not covered
Standard anti-reflective coating	\$45	Not covered	\$45	Not covered	\$10	Up to \$25	\$0	Up to \$25
Premium anti-reflective coating								
• Tier 1	\$57	Not covered	\$57	Not covered	\$22	Up to \$25	\$22	Up to \$25
• Tier 2	\$68	Not covered	\$68	Not covered	\$33	Up to \$25	\$33	Up to \$25
• Tier 3	80% of charge	Not covered	80% of charge	Not covered	80% of charge less \$35 allowance	Up to \$25	80% of charge less \$35 allowance	Up to \$25
Standard progressive (add-on to bifocal)	\$25	Up to \$40	\$15	Up to \$40	\$10	Up to \$40	\$0	Up to \$40
Premium progressive								
• Tier 1	\$110	Not covered	\$110	Not covered	\$45	Up to \$40	\$45	Up to \$40
• Tier 2	\$120	Not covered	\$120	Not covered	\$55	Up to \$40	\$55	Up to \$40
• Tier 3	\$135	Not covered	\$135	Not covered	\$70	Up to \$40	\$70	Up to \$40
• Tier 4	\$90 copay, 80% of charge less \$120 allowance	Not covered	\$90 copay, 80% of charge less \$120 allowance	Not covered	\$25 copay, 80% of charge less \$120 allowance	Up to \$40	\$25 copay, 80% of charge less \$120 allowance	Up to \$40
Photochromatic / plastic transitions	\$75	Not covered	\$75	Not covered	\$75	Not covered	\$75	Not covered
Polarized	20% off retail	Not covered	\$20% off retail	Not covered	20% off retail	Not covered	20% off retail	Not covered

(4) Lens option costs may vary by provider.

	100		130 / Materials Only 130		160 / Materials Only 160		200	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Contact lenses⁵ (materials only)								
Conventional	\$100 allowance 15% off balance over \$100	\$80 allowance	\$130 allowance 15% off balance over \$130	\$104 allowance	\$160 allowance 15% off balance over \$160	\$128 allowance	\$200 allowance 15% off balance over \$200	\$160 allowance
Disposable	\$100 allowance	\$80 allowance	\$130 allowance	\$104 allowance	\$160 allowance	\$128 allowance	\$200 allowance	\$160 allowance
Medically necessary	\$0	\$200 allowance	\$0	\$200 allowance	\$0	\$210 allowance	\$0	\$210 allowance
Frequency								
Exam ¹	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses or contact lenses	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
Frames	Once every 24 months		Once every 24 months		Once every 24 months		Once every 24 months	
Plan options								
12-month frame benefit	Benefit replaces the 24-month frequency of the base plan							
Retinal imaging ¹	\$0 in-network and up to \$20 for out-of-network benefits (does not cross apply)							
LASIK / PRK ¹	\$250 per eye (in- or out-of-network); 12-month waiting period applies							
Eye glass & contact lens benefit	Allows fulfillment of frame plus spectacle lenses in addition to the contact lens benefit of the base plan (not available for groups < 100)							
Polycarbonate lenses for children <19	Provides for standard polycarbonate lens with \$0 copay							

- (1) Not covered on Materials Only 130 and 160
- (2) Member costs may exceed \$39 with certain providers.
- (3) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.
- (4) Lens option costs may vary by provider.
- (5) Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Members may contact their participating provider to determine what costs or discounts are available.

EXAM PLUS

	In-network	Out-of-network
Routine eye exam		
With dilation	\$10	Up to \$30
Retinal imaging ¹	Up to \$39	Not covered
Contact lens exam²		
Standard contact lens fitting & follow-up	Up to \$55	Not covered
Premium contact lens fitting & follow-up	10% off retail	Not covered
Frames		
Discounts may be available on all frames except when prohibited by the manufacturer	35% off retail	Not covered
Standard plastic lenses³		
Single vision	\$50	Not covered
Bifocal	\$70	Not covered
Trifocal	\$105	Not covered
Lenticular	20% off retail	Not covered

(1) Member costs may exceed \$39 with certain providers

(2) Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider.

(3) Lens option costs may vary by provider.

Members may contact their participating provider to determine if listed costs are available.

	In-network	Out-of-network
Lens options		
UV coating	\$15	Not covered
Tint (solid & gradient)	\$15	Not covered
Standard scratch-resistance	\$15	Not covered
Standard polycarbonate	\$40	Not covered
Standard anti-reflective coating	\$45	Not covered
Standard progressive (add-on to bifocal)	\$65	Not covered
Polarized	20% off retail	Not covered
Add-on service	20% off retail	Not covered
Contact lenses (materials only)		
Conventional	15% off retail	Not covered
Disposable	Not covered	Not covered
Medically necessary	Not covered	Not covered
Frequency		
Exam	Once every 12 months	
Lenses or contact lenses	Not covered	
Frames	Not covered	

ADDITIONAL VISION PLAN DISCOUNTS

Type	Discount
Member may receive a 20% discount on items not covered by the plan at network Providers	<ul style="list-style-type: none"> Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
LASIK & PRK	<ul style="list-style-type: none"> Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location.

In NJ and MA, any services received for emergency care will pay at the same level of benefits for preferred and non-preferred providers.



	4-9 employees	10-99 employees	
	Options		Definitions
Employee contribution	<input type="checkbox"/> Contributory (6-9 employees) <input type="checkbox"/> Non-contributory (4-9 employees)	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary	<ul style="list-style-type: none"> • Contributory: employee pays a share of the premium • Non-contributory: Employer pays 100% of the employee’s premium • Voluntary: Employee pays 100% of the premium
Employer contribution	0-100%		Employer pays a percentage of the premium
Benefit options	<input type="checkbox"/> Flat benefit amount: \$100, \$200 or \$250 <input type="checkbox"/> Benefit percentage: 60% Weekly benefit maximum: \$100 – \$1,000	<input type="checkbox"/> Flat benefit amount: \$100 – \$600 <input type="checkbox"/> Benefit percentage: 60% or 66.67% Weekly benefit maximum: \$100 – \$2,500	<ul style="list-style-type: none"> • Flat benefit: Employee will receive payments at the weekly flat amount selected, not to exceed 66.67% of pre-disability earnings • Benefit percentage: Employee will receive payments at the percentage selected up to the weekly benefit maximum • Weekly benefit maximum: Benefit will be paid weekly if employee qualifies and meets the definition of disability. Benefit maximum available to the group cannot exceed the average of the top three salaries
Weekly benefit minimum	\$25		Minimum benefit to be paid if employee meets definition of disability
Elimination periods	Accident / sickness benefits begin: <input type="checkbox"/> 1 day / 8 days <input type="checkbox"/> 8 days / 8 days <input type="checkbox"/> 15 days / 15 days		Number of consecutive days after becoming disabled before the benefit becomes payable. For example: “1 day / 8 days” means the member will be covered on the first day if unable to work due to an accident and the eight day if unable to work due to a sickness under doctor’s orders.
Benefit duration	<input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks		The length of time disability payments will be made to the employee
Pre-existing condition limitation	Look-back / insured: <input type="checkbox"/> 3 / 12 months		A pre-existing condition is any injury or sickness the employee received medical care for: <ul style="list-style-type: none"> • Look-back period: Number of months before the effective date to determine if a medical condition is considered pre-existing • Insured period: Waiting period, beginning with the effective date of coverage, before the pre-existing condition is covered
Definition of disability	<ul style="list-style-type: none"> • Total disability: Employee is prevented from performing the essential duties of their occupation and is earning less than 20% of their pre-disability earnings • Disabled & working: Employee is prevented from performing some, but not all their essential duties, and are working part-time or limited-duty. And as a result, their current earnings are more than 20%, but are less than 80% of their pre-disability earnings. 		



	4-9 employees	10-99 employees	
	Options		Definitions
Employee contribution	<input type="checkbox"/> Contributory (6-9 employees) <input type="checkbox"/> Non-contributory (4-9 employees)	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary	<ul style="list-style-type: none"> • Contributory: employee pays a share of the premium • Non-contributory: Employer pays 100% of the employee’s premium • Voluntary: Employee pays 100% of the premium
Employer contribution	0-100%		Employer pays a percentage of the premium
Benefit percentage	<input type="checkbox"/> 60%	<input type="checkbox"/> 60% <input type="checkbox"/> 66.67% (non-contributory only)	Benefits are available to employees if definition of disability is met. The employee will receive payments at the percentage selected, up to the monthly benefit maximum. Benefit amount subject to integration of other income benefits.
Monthly benefit minimum	10% of monthly or \$100	<input type="checkbox"/> 10% of monthly or \$100 <input type="checkbox"/> \$100	Minimum benefit to be paid if employee meets the definition of disability. If 10% is less than \$100, benefit is \$100.
Monthly benefit maximum	\$3,000 – \$5,000	\$3,000 – \$10,000	Maximum benefit will be paid monthly if employee qualifies and meets the definition of disability (the average of the top three salaries determines the maximum available benefit)
Elimination periods	<input type="checkbox"/> 90 days <input type="checkbox"/> 180 days		Number of consecutive days after becoming disabled before the benefit becomes payable. To satisfy the elimination period, a loss of earnings is not required – only a loss of duties
Benefit duration	Social Security normal retirement age (SSNRA)		Length of time disability payments will be made to the employee. Benefits can last until retirement age as defined by the Social Security Administration.
Definition of disability	<input type="checkbox"/> 2-year own occupation	<input type="checkbox"/> 2-year own occupation <input type="checkbox"/> Own occupation to 65	<ul style="list-style-type: none"> • Employee is prevented from performing one or more of the essential duties of his or her occupation during the elimination period selected • Employee is prevented from performing essential duties of the occupation and has a specified percentage loss of earnings for period of time selected • After own occupation period ends, employee is prevented from performing essential duties of “any occupation”



	4-9 employees	10-99 employees	
	Options		Definitions
Pre-existing condition limitation (in months)	Look-back / insured: 12/24	Look-back / treatment-free / insured: 3/3/12	<p>A pre-existing condition is an injury or sickness the employee received medical care for during the look-back period.</p> <ul style="list-style-type: none"> • Look-back period: Number of months before the effective date to determine if a medical condition is considered pre-existing • Insured period: Waiting period, beginning with the effective date of coverage, before the pre-existing condition is covered.
Survivor benefit	Three times gross benefit		If employee dies while receiving disability benefits, survivor receives a lump sum equal to three times the employee's gross monthly benefit prior to death.
Employee Assistance Plan	Available with non-contributory plans		Online resources providing access to legal, financial, childcare, eldercare, and caregiver resources. Unlimited telephonic assistance and three face-to-face counseling sessions.
Social Security offset	Any benefits provided by Social Security will be offset for both you and your family.		
Mental illness limitation	If disabled due to mental illness, benefits may be payable for up to 24 months during employee's lifetime		
Substance disorder limitation	If disabled due to substance disorder, benefits may be payable for up to 24 months during employee's lifetime		
Recurrent disability	Returning to work during the elimination period of recovery will not interrupt the elimination period. If an employee returns to work as an active full-time employee after the elimination period for up to six months, and then becomes disabled again, they will resume the original disability and not be required to satisfy the elimination period again. This applies only if the recurred disability is due to the same (or related) cause as the original disability.		
Return to work incentive	Humana will actively guide and encourage employees' efforts to return to work, if appropriate. Our team of professionals will assess an employee's disability to determine the appropriate resources and support such as, vocational testing & training, alternative treatment plans, and workplace modifications. This incentive allows benefits plus earnings to replace 100% of the pre-disability earnings for a specified time.		
Rehabilitation program	Employees may be eligible for a rehabilitation bonus equal to their monthly benefit if they complete an approved rehabilitation program. Program examples include vocational testing and training, workplace modification, job placement, transitional work, and alternative treatment options.		



BASIC GROUP TERM LIFE

Provides basic coverage to employees while giving them the opportunity to purchase voluntary term life. You can change the amount of basic life coverage once a year, on the anniversary date, by making the request to underwriting.

EMPLOYEE Basic Term Life			
Available coverage	<ul style="list-style-type: none"> Flat amounts in \$1,000 increments Multiples of salary rounded to the next \$1,000 Class schedules: No more than 2.5 times between the classes and 10 times between the highest and lowest classes 		
Minimum	\$15,000		
Maximum	Lesser of seven times annual salary or \$1 million, combined with voluntary life		
DEPENDENT Basic Term Life ¹			
	Option 1	Option 2	Option 3
Spouse ²	\$20,000	\$10,000	\$5,000
Dependent child:			
• Ages 6 months to 26 years	\$5,000	\$2,500	\$1,000
• Ages 15 days to 6 months	\$1,000	\$500	\$500
• Birth through 14 days	No benefit	No benefit	No benefit
	Option 4	Option 5	Option 6
Spouse ²	\$20,000	\$10,000	\$10,000
Dependent child:			
• Ages 6 months to 26 years	\$10,000	\$5,000	\$10,000
• Ages 15 days to 6 months	\$1,000	\$1,000	\$1,000
• Birth through 14 days	No benefit	No benefit	No benefit

- Option 1 is available for groups with five or more eligible lives. Options 2 & 3 are available for groups with two or more eligible lives.
- Guarantee issue amounts for spouse/children coverage are equal to the benefit selected. Coverage and eligibility terminates at age 65.

Guaranteed issue amounts

For groups of two or more, Humana guarantees that eligible employees, spouses, and dependent children will receive a specified amount of life coverage without medical underwriting. Amounts vary with the number of full-time eligible employees.

Eligible lives	Maximum guaranteed issue amounts
2 – 4	Up to \$25,000
5 – 9	Up to \$50,000
10 – 24	Up to \$100,000
25 – 50	Up to \$175,000
51 – 74	Up to \$200,000
75 – 99	Up to \$250,000
100 – 299	Up to \$300,000

Minimum participation requirements

The minimum employer contribution for groups with two or more eligible employees is 50% of premium.

Employer contribution	Participation
100% of premium	100%
50-99% of premium	50%

Retirees: Basic Term Life is not available to retired employees.



VOLUNTARY / SUPPLEMENTAL TERM LIFE

Available to groups with five or more eligible employees. Employees receive group rates and pay premiums through payroll deductions.

EMPLOYEE Voluntary Term Life	
Available coverage	Flat amounts in \$1,000 increments
Minimum	\$15,000
Maximum	<ul style="list-style-type: none"> • \$250,000 for groups with 5 to 50 employees¹ • \$500,000 for groups with 51 or more employees • \$1 million, combined with Basic Term Life
DEPENDENT Basic Term Life ¹	
Spouse:	
<ul style="list-style-type: none"> • Available coverage • Minimum coverage • Maximum coverage 	\$1,000 increments up to 50% of employee amount \$5,000 \$250,000
Dependent child:	
<ul style="list-style-type: none"> • Ages 6 months to 26 years • Ages 15 days to 6 months • Birth through 14 days 	\$5,000 or \$10,000 \$500 No benefit

(1) Other options available upon underwriting approval.

Guaranteed issue amounts

Amounts are based on the number of full-time eligible employees. Guaranteed issue does not apply to employees age 65 and older or spouses age 60 and older.

Eligible lives	Employee	Spouse
5 – 9	None	None
10 – 24	Up to \$50,000	Up to \$25,000
25 – 29	Up to \$75,000	Up to \$35,000
30 – 50	Up to \$75,000	Up to \$35,000
51 – 74	Up to \$100,000	Up to \$50,000
75 – 299	Up to \$100,000	Up to \$50,000

Minimum participation requirements:

Five enrolled employees or 25%, whichever is greater.

Retirees:

Voluntary life is not available to retired employees.



BASIC & VOLUNTARY PLAN PROVISIONS

Rate guarantee

Rates guaranteed to not change for two years (three years, if offered).

Age reduction options

Choose one of the schedules at time of sale. Beginning at age 65 or age 70 (Schedule 3), the employee’s life coverage is reduced based on the benefit amount in force on their 64th or 69th (Schedule 3) birthday. This also applies to AD&D.

Age	Schedule 1	Schedule 2	Schedule 3
65	35%	35%	No reduction
70	55%	50%	50%
75	70%		
80	80%	No further reduction	
85	85%		

Waiver of premium

- Employees who are disabled for at least six consecutive months before age 60 can continue life insurance coverage and waive the premium
- Employee is covered until age 65 if they remain totally disabled

Guaranteed conversion

- If employee or dependent loses coverage due to the employee’s loss of employment, loss of eligibility, or reduction for age, the coverage can be converted to an individual whole life insurance policy
- Maximum amounts to be converted vary based on the certificate
- If group coverage ends due to termination of the policy, conversion is available when the member’s coverage has been in effect for at least three years
- Voluntary ported coverage also can be converted when the policy is terminated
- Conversion policy is issued without evidence of insurability and must be applied and paid for within 31 days of coverage termination

Accelerated death benefit

- An employee diagnosed with a terminal illness that is expected to result in death within 24 months based on the plan offered can receive a portion of the insurance benefit
- Amount payable is 50% to a maximum benefit of \$250,000
- The advanced amount will reduce the life insurance benefit at the time of death (varies by state regulations)
- Humana must approve the benefit application

Residents of AL, IL, IN, MA, MI, OH, OK, VA, and WA must have continuous coverage a minimum of 30 days to qualify for illness coverage. Residents of Texas must have continuous coverage a minimum of six months to qualify for illness coverage. For accidents, coverage begins on the effective date of the policy.

Portability of voluntary life

- An active eligible employee who leaves the group can continue voluntary life insurance by paying annual premiums to Humana if they are not yet age 70
- Only coverage in-force or a lesser amount can be ported
- Employee must exercise portability option with 31 days of termination
- Employees will be charged Humana’s current portability rates when they leave

Portability is state-specific and is not available in NJ, MN, and MA. For specific benefits of coverage, contact your sales representative or refer to your Certificate of Coverage.



ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS (AD&D)

AD&D must be purchased with life benefits for employees (dependent children are not eligible for AD&D). AD&D provides a matching death benefit equal to the life schedule amount and includes the following features:

Common carrier benefit

Paid after a covered accidental bodily injury sustained while riding as a fare-paying passenger in a common carrier. A common carrier is any land, air, or water vehicle operated with a valid license to transport passengers for hire.

Seatbelt, airbag, helmet benefit

- **Seat belt benefit** – paid after death as a result of an auto accident while properly using a seat belt
- **Airbag** – paid after death as a result of an auto accident while driving a vehicle with a properly functioning airbag
- **Helmet** – paid after death as a result of a motorcycle accident while wearing a properly fitted and fastened motorcycle helmet

Education benefit

Provides financial assistance for dependent children's higher education in the event of a covered parent's death.

Childcare benefit

Provides financial assistance for expenses for dependent children's childcare in the event of covered spouse's death.

Spouse training benefit

Provides financial assistance for spouse's studies at an accredited school in the event of covered spouse's death.

Repatriation benefit

Provides financial assistance for transportation of the employee's body in the event of accidental death. Contract will establish mileage requirements from principal place of residence.

Coma benefit

Paid if covered person is in a qualifying coma condition.

AD&D provisions for employees and spouse¹

If death or the following losses occur within 180 days of an accident, the following benefit will be paid:

Loss	Benefit amount equal to
Life	Full amount
Both hands and both feet	Full amount
Sight in both eyes	Full amount
One hand and one foot	Full amount
One hand or one foot, and sight in one eye	Full amount
One hand or one foot	50% of full amount
Loss of sight in one eye	50% of full amount
Loss of thumb and index finger on same hand	25% of full amount
Quadriplegia	Full amount
Paraplegia or hemiplegia	50% of full amount

(1) Benefits may vary by state. Please consult your policy for details

Residents of Texas must have continuous coverage a minimum of 30 days to qualify for AD&D coverage. For benefits details, refer to your Certificate of Coverage.

The fine print

This material provided is a general summary for informational purposes only and does not address all your organization's specific issues related to healthcare reform. It is not intended or written to be used, and it cannot be used, as legal advice or a legal opinion. It should not be relied upon in lieu of consultation with your own legal advisors.

MEDICAL PLANS:

Provider disclaimer:

Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

This medical policy does not provide any dental benefits to individuals age nineteen (19) or older. This medical policy provides pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a dental policy that has adult dental benefits. This medical policy will not pay for any adult dental care, so you will have to pay the full price of any care you receive if you do not have a separate dental policy.

Wellness programs are not insurance products.

Offered by Humana Health Plan, Inc. and insured by Humana Insurance Company.

DENTAL PLANS:

Insured or administered by Humana Insurance Company, or Offered by CompBenefits Dental, Inc

VISION PLANS:

Insured by Humana Insurance Company

LIFE & DISABILITY PLANS:

Insured by Humana Insurance Company or Kanawha Insurance Company

LIMITATIONS & EXCLUSIONS

Limitations and Exclusions:

Our benefit plans have limitations and exclusions and may have waiting periods and terms under which the coverage may be continued in force or discontinued. For costs and complete details of coverage, call or write your Humana insurance agent or broker.

Before applying for group coverage, please refer to the pre-enrollment disclosures for a description of plan provisions, which may exclude, limit, reduce, modify or terminate your coverage. These disclosures are available at <https://www.humana.com/insurance-through-employer/enrollment-center/pre-enrollment-disclosure> or through your sales representative.



Policy numbers: CC2003-P 18 S, CHMO 2004-P 18 S, CHMO 2004-P 18 POS S, CC2003-P 18 POS S, IL-70148-01 LG 9/15, IL-70148-01 SG 9/15, IL-70090-HC 1/14, IL-70090-HC 1/14 S, IL DPREPD Contract.001, 1687 IL, IL-70050-07 EM POLICY 5/06