Humana Dental Plans - Illinois

Effective as of 11/1/2014

	DHMO	PPO
	HumanaOne® Dental Value C550	HumanaOne® Dental Preventive Plus
On the Marketplace	Not Available	Not Available
Off the Marketplace	Benefit Summary	Benefit Summary
Deductible	$0	Plan Year: Individual $50; Family: $150
Annual Maximum Per Individual on Plan*	No annual maximum	$1,000
Max Out-of-Pocket** (Humana® Dental Smart Choice Pediatric only)	Not Available	Not Available
Network Coverage	In network	In- and out-of-network
Preventative Services (covers items, such as oral exams, cleanings, and x-rays)	$10-$15 office copayment (in network)	100% no deductible (in network); 70% of in network fee schedule after deductible (out-of-network)
Basic Services (covers items, such as fillings, nonsurgical extractions, and oral surgery)	Benefits available. Refer to plan summary for details.	50% after deductible (in network); 30% of in network fee schedule after deductible (out-of-network)
Major Services (covers items, such as root canals, dentures, and bridgework)	Benefits available. Refer to plan summary for details.	Average savings of 28% (in network)
Medically Necessary (covers orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palette with or without cleft lip)	Not Available	Not Available
Monthly Premium	$14†	$23†

*This is the maximum amount that the plan will pay during the plan year **Out-of-pocket maximum for a policy with one covered child is $350. The out-of-pocket maximum for a policy with two or more covered children is $350 per individual child or $700 combined for all children.

† Single rate for age 42

Humana Dental Plans continued on next page

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Humana Dental Smart Choice plan is available on the Health Insurance Marketplace

Humana Dental Plans - Illinois

Effective as of 11/1/2014

	PPO	
	Humana® Dental Smart Choice	
	Adult Individual/Family	Pediatric
On the Marketplace	Benefit Summary	Benefit Summary
Off the Marketplace	Not Available	Not Available
Deductible	Individual: $50 - $150 Family: $50-$150 per member	$50 - $150 per member
Annual Maximum Per Individual On Plan*	$1,000 for adults No annual maximum for children	No annual maximum
Max Out-of-Pocket** (Humana® Dental Smart Choice Pediatric only)	$350 for 1 child/$700 2+ children	$350 for 1 child/$700 2+ children
Network Coverage	In- and out-of-network	In- and out-of-network
Preventative Services (covers items, such as oral exams, cleanings, and x-rays)	100% no deductible (in network); 70%-100% after deductible (out-of-network)	90% - 100% after deductible (in network); 70%-100% after deductible (out-of-network)
Basic Services (covers items, such as fillings, nonsurgical extractions, and oral surgery)	50% - 80% after deductible (in- and out-of-network) 6 month waiting period	40%-80% after deductible (in network); 30%-80% after deductible (out-of-network); No waiting period
Major Services (covers items, such as root canals, dentures, and bridgework)	Children up to age 19 only: 40% - 60% after deductible (in- and out-of-network); No waiting period	40% - 60% after deductible (in- and out-of-network); No waiting period
Medically Necessary (covers orthodontic treatment as a result of congenital or developmental malformation which are related to or developed as a result of cleft palette with or without cleft lip)	Children only: 50% after deductible (in- and out-of-network)	50% after deductible (in- and out-of-network)
Monthly Premium	$23†	$35††

*This is the maximum amount that the plan will pay during the plan year **Out-of-pocket maximum for a policy with one covered child is $350. The out-of-pocket maximum for a policy with two or more covered children is $350 per individual child or $700 combined for all children.
† Single rate for age 42 in Region 1 †† Single rate for ages 0-20 in Region 1

Previous page contains additional Humana Dental Plans

Humana Dental Smart Choice plan is available on the Health Insurance Marketplace

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Humana Vision Plans - Illinois

Effective as of 11/1/2014

	HumanaOne Vision Care Plan	
	In-network Provider	Out-of-network Provider
On the Marketplace	Not Available	
Off the Marketplace	Benefit Summary	
Exam with Dilation as Necessary	100% after $10 copay	$35 allowance
Frames	$40 wholesale allowance	$40 retail allowance
Lenses		
Single Vision	100% after $25 copay	$25 allowance
Bifocal	100% after $25 copay	$40 allowance
Trifocal	100% after $25 copay	$60 allowance
Contact Lenses[1]		
Conventional[2]	$115 allowance	$90 allowance
Disposable[2]	$115 allowance	$90 allowance
Medically Necessary (limit one pair)[3]	100%	$210 allowance
Frequency†	Option 1	Option 2
Examination	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Monthly Premium	$16*	

[1] If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames)

[2] The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members may be eligible to receive a 15 percent discount on in-network professional services. The discount for professional services is available for 12 months after the covered eye exam.

* Single rate example

† Frequencies are based on date of service

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