Illinois

Humana medical plans

For groups 1-50
Effective dates starting 1/1/2021

SIMPLICITY

PPO, NPOS, and HMO PLANS – With Simplicity, there is no in-network deductible to plan care around, and no coinsurance percentages to calculate. For healthcare services, members pay only a copayment when in-network providers are used, so they know exactly what they'll pay before they see a doctor, making it easier to prepare for any health need. In-network preventive services, such as annual exams and flu shots, are covered at 100%. Virtual Visits through Doctor On Demand (DOD) have a $0 copay and can be used for non-emergency care. All other virtual visits (with other providers) will be equal to the cost associated with the same in-person/face-to-face site of care. All copayments, including prescription drugs, count toward the out-of-pocket limit that helps protect members' total annual spending.

If you use IN-NETWORK providers

							Copayment amounts:					
Option	Metallic tier	Coinsurance In	Coinsurance Out	Deductible	Out-of-pocket limit Individual	Out-of-pocket limit Family	Primary care/ Specialist	Doctor on Demand®	Retail clinic/ Urgent care/ER	Advanced imaging	Ambulatory Surgical Center / Outpatient / Inpatient[1] services	Pharmacy
1[2]	Gold	100%	50%	$0	$6,500	$13,000	$40/$80	$0	$20/$100/$500	$500	$500/$1,000/$1,250	$5/$15/$75/$150/$1,200
2	Gold	100%	50%	$0	$6,500	$13,000	$40/$80	$0	$20/$100/$500	$500	$750/$1,250/$1,500	$5/$15/$75/$150/$1,200
3[2]	Gold	100%	50%	$0	$6,500	$13,000	$45/$90	$0	$20/$100/$500	$500	$1,000/$1,500/$1,750	$5/$15/$75/$150/$1,200
4[2]	Gold	100%	50%	$0	$6,500	$13,000	$45/$90	$0	$20/$100/$500	$500	$1,250/$1,750/$2,000	$5/$15/$75/$150/$1,200
5	Gold	100%	50%	$0	$8,550	$17,100	$30/$60	$0	$20/$100/$750	$750	$1,500/$2,000/$2,250	$5/$15/$75/$150/$1,200
6[2]	Gold	100%	50%	$0	$8,550	$17,100	$45/$90	$0	$20/$100/$650	$650	$1,500/$2,000/$2,250	$5/$15/$75/$150/$1,200

1 Inpatient Copayment per day for first three days.

2 HMO Select network available with these options.

Illinois

Humana medical plans

For groups 1-50
Effective dates starting 1/1/2021

COPAY

PPO and NPOS PLANS – These traditional plan designs offer members predictable costs with copayments for most types of healthcare services, giving members the security of coverage and financial protection. In-network preventive services, such as annual exams and flu shots, are covered at 100%. Virtual Visits through Doctor On Demand have a $0 copay and can be used for non-emergency care. All other virtual visits (with other providers) will be equal to the cost associated with the same in-person/face-to-face site of care. For other covered services, members pay until the deductible is met, then pay coinsurance. All out-of-pocket costs, including prescription drugs, count toward the out-of-pocket limit that helps protect members' total annual spending.

If you use IN-NETWORK providers

								Copayment amounts:					
Option	Metallic tier	Coinsurance In	Coinsurance Out	Deductible Individual	Deductible Family	Out-of-pocket limit Individual	Out-of-pocket limit Family	Primary care/ Specialist	Doctor on Demand®	Retail clinic/ Urgent care	ER	Pharmacy	Other covered services
1	Gold	100%	50%	$2,000	$4,000	$6,000	$12,000	$45/$90	$0	$20/$100	$500	$5/$15/$75/$150/$1,200	Ded/Coins
2	Gold	80%	50%	$1,000	$2,000	$5,000	$10,000	$45/$90	$0	$20/$100	$500 + 20%	$5/$15/$75/$150/$1,200	Ded/Coins
3	Gold	80%	50%	$3,000	$6,000	$5,500	$11,000	$40/$80	$0	$20/$100	$550 + 20%	$5/$15/$75/$150/$1,200	Ded/Coins
4	Silver	50%	50%	$3,500	$7,000	$8,550	$17,100	$50/$100	$0	$20/$100	$825 + 50%	$5/$15/$75/$150/$1,200	Ded/Coins

Illinois

Humana medical plans

For groups 1-50
Effective dates starting 1/1/2021

CANOPY

PPO and NPOS PLANS – Canopy offers copayments for the healthcare services members use most, like a primary care office exam, specialist office exam, retail clinic, urgent care, and pharmacy services. Virtual Visits through Doctor On Demand have a $0 copay and can be used for non-emergency care. All other virtual visits (with other providers) will be equal to the cost associated with the same in-person/face-to-face site of care. For all other in-network services, including any lab work or x-rays done in conjunction with an office visit, or more serious health issues, members pay until the deductible is met, then pay coinsurance. All in-network preventive services, such as annual exams and flu shots, are covered at 100% with no copayment. All out-of-pocket costs, including prescription drugs, count toward the out-of-pocket limit that helps protects members' total annual spending.

If you use IN-NETWORK providers

								Copayment amounts:				
Option	Metallic tier	Coinsurance In	Coinsurance Out	Deductible Individual	Deductible Family	Out-of-pocket limit Individual	Out-of-pocket limit Family	Primary care / Specialist	Doctor on Demand®	Retail clinic/ Urgent care	Pharmacy	Other covered services including emergency room
1	Silver	100%	50%	$7,000	$14,000	$8,550	$17,100	$45/$90	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
2	Gold	80%	50%	$3,500	$7,000	$5,500	$11,000	$25/$50	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
3	Silver	80%	50%	$6,000	$12,000	$8,550	$17,100	$40/$80	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
4	Silver	50%	50%	$2,500	$5,000	$8,550	$17,100	$45/$90	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
5	Silver	50%	50%	$3,000	$6,000	$8,550	$17,100	$40/$80	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
6	Silver	50%	50%	$5,000	$10,000	$8,550	$17,100	$40/$80	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
7	Silver	50%	50%	$6,000	$12,000	$8,550	$17,100	$40/$80	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins
8	Silver	50%	50%	$7,000	$14,000	$8,550	$17,100	$45/$90	$0	$20/$100	$5/$15/$75/$150/$1,200	Ded/Coins

For groups 1-50
Effective dates starting 1/1/2021

EFFICIENCY

PPO and NPOS PLANS – Efficiency coinsurance plans typically offer the lowest average premiums in exchange for members taking on more cost responsibility. All in-network preventive services, such as annual exams and flu shots, are covered at 100% with no copayment. Virtual Visits through Doctor On Demand have a $0 copay and can be used for non-emergency care. All other virtual visits (with other providers) will be equal to the cost associated with the same in-person/face-to-face site of care. For all other in-network covered services, members pay until the deductible is met, then pay coinsurance. All out-of-pocket costs, including prescription drugs, count toward the individual and family deductible, as well as the out-of-pocket limit that helps protect members' total annual spending.

If you use IN-NETWORK providers

								Copayment amounts:		
Option	Metallic tier	Coinsurance In	Coinsurance Out	Deductible Individual	Deductible Family	Out-of-pocket limit Individual	Out-of-pocket limit Family	Doctor on Demand®	Pharmacy	Other covered services
1	Bronze	100%	50%	$8,550	$17,100	$8,550	$17,100	$0	Ded / Coins	Ded/Coins
2	Bronze	80%	50%	$7,200	$14,400	$8,550	$17,100	$0	Ded / Coins	Ded/Coins
3	Bronze	50%	50%	$6,100	$12,200	$8,550	$17,100	$0	Ded / Coins	Ded/Coins
4	Bronze	50%	50%	$7,000	$14,000	$8,550	$17,100	$0	Ded / Coins	Ded/Coins

Illinois

Humana medical plans

For groups 1-50
Effective dates starting 1/1/2021

Savings HSA

PPO, NPOS, and HMO PLANS – Savings HSA plans are Humana's high-deductible health plans (HDHPs), the only plans eligible for Health Savings Accounts (HSA) which allow members to save pre-tax dollars for future health expenses, giving them more out of their paycheck. High deductibles also help to lower premiums and offer more financial flexibility in how members save their money, whether through the HSA or however they wish. Additionally, all in-network preventive services are covered at 100% with no copayment, such as annual exams and flu shots. Members are also protected by an annual out-of-pocket maximum, so they always know the most they'll pay that year on covered services before Humana covers all eligible services at 100%, providing financial predictability and protection.

EMBEDDED – All covered benefits apply to the individual and family deductible and maximum out-of-pocket. When a family member reaches their individual deductible amount, that individual 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		Out-of-pocket limit		Pharmacy	Other covered services
		In	Out	Individual	Family	Individual	Family		
1	Bronze	90%	50%	$6,500	$13,000	$6,900	$13,800	Ded / Coins	Ded/Coins
2	Silver	80%	50%	$3,000	$6,000	$6,000	$12,000	Ded / Coins	Ded/Coins
3	Bronze	70%	50%	$6,200	$12,400	$6,900	$13,800	Ded / Coins	Ded/Coins
4[1]	Bronze	50%	50%	$6,000	$12,000	$6,900	$13,800	Ded / Coins	Ded/Coins

1 HMO Select network available with these options.

Illinois

Humana medical plans

For groups 1-50
Effective dates starting 1/1/2021

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, Lake	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 Plan **If you use IN-NETWORK provider**

Option	Metallic tier	Coinsurance In	Deductible	Out-of-pocket limit Individual	Family	Copayment amounts: Primary care/ Specialist	Doctor on Demand®	Retail clinic/ Urgent care/ER	Advanced imaging	Ambulatory Surgical services / Outpatient / Inpatient	Pharmacy
101 - 107	Gold	100%	$0	$6,500	$13,000	$40/$80	$0	$20/$100/$500	$500	$500/$1,000/$1,250	$5/$15/$75/$150/$1,200
108 - 114	Gold	100%	$0	$6,500	$13,000	$45/$90	$0	$20/$100/$500	$500	$1,000/$1,500/$1,750	$5/$15/$75/$150/$1,200
115 - 121	Gold	100%	$0	$6,500	$13,000	$45/$90	$0	$20/$100/$500	$500	$1,250/$1,750/$2,000	$5/$15/$75/$150/$1,200
122 - 128	Gold	100%	$0	$8,550	$17,100	$45/$90	$0	$20/$100/$650	$650	$1,500/$2,000/$2,250	$5/$15/$75/$150/$1,200

Humana HMO Savings HSA Plan **If you use IN-NETWORK provider**

Option	Metallic tier	Coinsurance In	Deductible Individual	Family	Out-of-pocket limit Individual	Family	Pharmacy	Other services
136 - 142	Bronze	50%	$6,000	$12,000	$6,900	$13,800	Ded / Coins	Ded/Coins

Illinois

Humana medical plans

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.

PPO Plans:

- **Humana ChoiceCare Network® (CHC)** is one of the largest, most cost-effective physician and hospital networks in the nation. Members can visit any participating network provider at any time.

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 provider 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 22,000 independent pharmacies, along with Humana's mail delivery and specialty pharmacies.

Illinois

Humana dental plans

Traditional Preferred

Flexible plan with low deductibles and the 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 deductible[1]	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 options[2] (available for 2+ size groups):

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

Enrollment options[3]

- **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 10+

(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

Illinois

Humana dental plans

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	In-network	Out-of-network
Calendar-year deductible[1]	Option 1		Option 2		Option 3		Option 4	
Individual / Family	$25/$75	$50/$150	$50/$150	$50/$150	$50/$150	$100/$300	N/A	N/A
Coinsurance	Option 1		Option 2		Option 3		Option 4	
Preventive services	100%	100%	100%	100%	100%	80%	100%	80%
Basic services	100%	80%	90%	80%	80%	50%	80%	80%
Major services	60%	50%	60%	50%	50%	50%	50%	50%

Funding options[2] (available for 2+ size groups):

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

Enrollment options[3]

- **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	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 10+
(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

Illinois

Humana dental plans

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	$1,000	
Calendar-year deductible[1]		
Individual / Family	$50/$150	
Coinsurance	Option 1	Option 2
Preventive services	100%	100%
Basic services (Emergency care, fillings, & simple extractions)	80%	50%

Funding options[2] (available for 2+ size groups):

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

Enrollment options[3]

- **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
Composite fillings for molars	Covers composite fillings on molar teeth at Basic services coinsurance amount

Discount services:
Not covered, but may be available at a discount through their dentist

- Additional basic services (crowns, harmful habit appliances for children, oral surgery)
- Major services
- Orthodontia services

(1) Deductible does not apply to Preventive services
(2) Multiple product options may be offered for groups of 10+
(3) If you don't choose an option, open enrollment will apply

Illinois

Humana dental plans

DHMO

On DHMO dental plans, there are no yearly maximums, no deductibles to meet, and no waiting periods.

For HD plans, member costs listed are for services provided by a chosen participating primary care dentist (PCD) only. HS plan copayments are applicable at either a participating PCD or a participating specialist.

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:

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. For HD plans, members may be eligible to receive up to a 25 percent discount by visiting a 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	Pediatric oral evaluation – established patient	$0	$0	$0
0210	Intraoral – complete series of radiographic images (x-ray)	$0	$0	$0
1110 / 1120	Prophylaxis – adult/child	$0	$0	$0
1206	Topical application of fluoride varnish (for child <16)	$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	Endodontic therapy, molar 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	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$0	$55	$60
Orthodontics				
8070 / 8080	Children up to 19 years of age, up to 24 months of routine orthodontic treatment for Class I and Class II cases	$1,900	$1,900	$1,900

Illinois

Humana dental plans

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 after 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

Illinois

Humana vision plans

	100	130 / Materials Only 130	150	160 / Materials Only 160	200	100 / 130 / 150 / 160 / 200
	In-network	In-network	In-network	In-network	In-network	Out-of-network
Routine eye exam						
With dilation[1]	$10	$10	$10	$10	$0	Up to $30
Retinal imaging[5]	Up to $39	Up to $39	Up to $39	Up to $39	Up to $39	Not Covered
Contact lens exam[2]						
Standard contact lens fit and follow-up	Up to $40	Up to $40	Up to $40	$0	$0	100 / 130 / 150: Not covered 160 and 200: Up to $30
Premium contact lens fit and follow-up	10% off retail	10% off retail	10% off retail	10% off retail less $55 allowance	10% off retail less $55 allowance	100 / 130 / 150: Not covered 160 and 200: Up to $30
Exam	$0	$0	$0	$0	$0	Up to $77
Retinal imaging	$0	$0	$0	$0	$0	Up to $50
Extended ophthalmoscopy	$0	$0	$0	$0	$0	Up to $15
Gonioscopy	$0	$0	$0	$0	$0	Up to $15
Scanning laser	$0	$0	$0	$0	$0	Up to $33
Frames[3]						
Discounts may be available on all frames except when prohibited by the manufacturer	$100 allowance 20% off balance over $100	$130 allowance 20% off balance over $130	$150 allowance 20% off balance over $150	$160 allowance 20% off balance over $160	$200 allowance 20% off balance over $200	100: $50 allowance 130: $65 allowance 150 / 160: $80 allowance 200: $100 allowance
Standard plastic lenses[4]						
Single vision	$25	$15	$10	$10	$0	Up to $25
Bifocal	$25	$15	$10	$10	$0	Up to $40
Trifocal	$25	$15	$10	$10	$0	Up to $60
Lenticular	$25	$15	$10	$10	$0	Up to $100

(1) Not covered on Materials Only 130 and 160

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

(4) Lens option costs may vary by provider

(5) Member costs may exceed $39 with certain providers

Illinois

Humana vision plans

	100	130 / Materials Only 130	150	160 / Materials Only 160	200	100 / 130 / 150 / 160 / 200
	In-network	In-network	In-network	In-network	In-network	Out-of-network
Lens options[1]						
UV coating	$15	$15	$15	$15	$15	Not Covered
Tint (solid & gradient)	$15	$15	$15	$15	$15	Not Covered
Standard scratch-resistance	$15	$15	$15	$15	$15	Not Covered
Standard polycarbonate	$40	$40	$40	$40	$40	Not Covered
Standard anti-reflective coating	$45	$45	$25	$10	$0	100 / 130: Not covered 150 / 160 / 200: Up to $25
Premium anti-reflective coating • Tier 1 • Tier 2 • Tier 3	 $57 $68 80% of charge	 $57 $68 80% of charge	 $37 $48 80% of charge less $20 allowance	 $22 $33 80% of charge less $35 allowance	 $22 $33 80% of charge less $35 allowance	Tiers 1, 2, and 3: 150 / 160 / 200: Up to $25 100 / 130: Not Covered
Standard progressive (add-on to bifocal)	$25	$15	$10	$10	$0	Up to $40
Premium progressive • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $110 $120 $135 $90 copay, 80% of charge less $120 allowance	 $110 $120 $135 $90 copay, 80% of charge less $120 allowance	 $75 $85 $100 $55 copay, 80% of charge less $120 allowance	 $45 $55 $70 $25 copay, 80% of charge less $120 allowance	 $45 $55 $70 $25 copay, 80% of charge less $120 allowance	Tiers 1, 2, 3, and 4: 150 / 160 / 200: Up to $40 100 / 130: Not Covered
Photochromatic / plastic transitions	$75	$75	$75	$75	$75	Not Covered
Polarized	20% off retail	20% off retail	20% off retail	20% off retail	20% off retail	Not Covered

(1) Lens option costs may vary by provider

Illinois

Humana vision plans

	100	130 / Materials Only 130	150	160 / Materials Only 160	200	100 / 130 / 150 / 160 / 200
	In-network	In-network	In-network	In-network	In-network	Out-of-network
Contact lenses[2] (materials only)						
Conventional	$100 allowance 15% off balance over $100	$130 allowance 15% off balance over $130	$150 allowance 15% off balance over $150	$160 allowance 15% off balance over $160	$200 allowance 15% off balance over $200	100: $80 allowance 130: $104 allowance 150 / 160: $128 allowance 200: $160 allowance
Disposable	$100 allowance	$130 allowance	$150 allowance	$160 allowance	$200 allowance	100: $80 allowance 130: $104 allowance 150 / 160: $128 allowance 200: $160 allowance
Medically necessary	$0	$0	$0	$0	$0	100/130: $200 allowance 150/160/200: $210 allowance
Frequency						
Exam[1]	Once every 12 months					
Lenses or contact lenses	Once every 12 months					
Frames	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) Plan covers contact lenses or lenses for 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

Illinois

Humana vision plans

EXAM PLUS

	In-network	Out-of-network
Routine eye exam		
With dilation[1]	$10	Up to $30
Retinal imaging[1]	Up to $39	Not Covered
Contact lens exam[2]		
Standard contact lens fit and follow-up	Up to $40	Not Covered
Premium contact lens fit and 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 lenses[3]		
Single vision	$50	Not Covered
Bifocal	$70	Not Covered
Trifocal	$105	Not Covered
Lenticular	20% off retail	Not Covered

	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 lens (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	

(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

Illinois

Humana vision plans

ADDITIONAL VISION PLAN DISCOUNTS

Type	Discount
Member may receive a 20% discount on items not covered by the plan at network providers	• Members may contact their participating provider to determine what costs or discounts are available. • Discount does not apply to EyeMed providers' 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, and Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
LASIK & PRK	• 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.

Illinois

Group term life

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	• 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 $1,000,000, combined with voluntary life		
DEPENDENT Basic Term Life[1]	Option 1	Option 2	Option 3
Spouses[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	$1,000	$500
• Birth through 14 days	No benefit	No benefit	No benefit

(1) 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.

(2) 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 amount
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% premium	Five enrolled employees or 50%, whichever is greater when written as stand-alone coverage Two enrolled employees or 50%, whichever is greater when written with Medical or Dental

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

Illinois

Group term life

VOLUNTARY / SUPPLEMENTAL TERM LIFE

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

EMPLOYEE Voluntarty Ter	
Available coverage	Flat amounts in $1,000 increments
Minimum	$15,000
Maximum	• $250,000 for groups with 5 to 50 employees[1] • $500,000 for groups with 51 or more employees • $1 million, combined with Basic Term Life
DEPENDENT Basic Term Life[1]	
Spouses	
• Available coverage	$1,000 increments up to 50% of employee amount
• Minimum coverage	$5,000
• Maximum coverage	$250,000
Dependent child:	
• Ages 6 months to 26 years	$5,000 or $10,000
• Ages 15 days to 6 months	$500
• Birth through 14 days	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.

Illinois

Group term life

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%	No further reduction	
80	80%		
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 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.

Coma benefit

Paid if covered person is in a qualifying coma condition.

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.

AD&D provisions for employees and spouse[1]

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 ADD coverage. For benefits details, refer to your Certificate of Coverage.

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.

This document is for reference only and is intended to provide a brief overview of plan benefits. For complete information and terms of coverage, please refer to plan documents.

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.

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

Wellness programs are not insurance products.

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

Dental Plans:

Insured or administered by Humana Insurance Company, or Offered by The Dental Concern, Inc.

Vision Plans:

Insured by Humana Insurance Company.

Life Plans:

Insured by Humana 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.

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