2024 Humana Producer Guide

For commercial group products
Group size 1–100

We believe our role in the insurance industry is to shift perceptions and move beyond being simply an insurance carrier. To that end, we work to empower our members and help them live healthy, active, and rewarding lives.

Humana.

GCHJW4PEN

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Humana employer group solutions

Wellness

Wellness solutions

Humana is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care.

The company's strategy integrates care delivery, the member experience and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

Go365

Understand the program and its differentiators in our employer brochure. Here are ways the program can help clients:

- 2-99 employer groups with Humana's fully insured medical plans can save up to 15% in **Wellness Engagement Incentive credits**. [Flyer] [FAQ]
- 100+ employer groups with Humana's fully insured medical plans can save up to 8% upon renewal through the **Wellness Premium Discount**. [Flyer] [FAQ]
- Total Health groups can save up to 12% on renewal premiums through the **Total Health Wellness Discounts**. [Brochure]

Find additional resources regarding how clients can get started and more on Go365 Engagement Source, available to all agents with a SAN and Go365 customers.

EAP

TELUS is a global leader in total well-being and will provide Employee Assistance Program (EAP) benefits to all commercial embedded and buy up groups going forward. Our collaboration with TELUS will allow clients and their employees to enjoy industry-leading benefits from a company dedicated to total well-being.

National footprint

National PPO Network

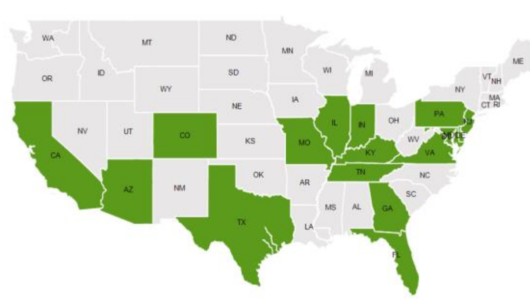
National POS Network

Dental PPO Network

Humana’s Dental PPO, Traditional Preferred and Preventive Plus plans all utilize the same dental provider network, but each have different Service areas. Green indicates a state is in area for any one of the networks, products or plans.

Humana Vision (Insight) Network

National DHMO Network



Who to contact

Pre-sale support

Quotes for new business (Easy Rate) | easyrate@humana.com

Quotes for in-force groups (Conservation) | conservation@humana.com or levelfunding@humana.com

New business submission | SBSales@humana.com

- Include group name in the subject line
- Include contact information in the email for case follow-up, if necessary
- Attach all new case paperwork in the required format

Post-sale support

Employee enrollment and/or change forms | **1-866-584-9140**
New hires, employee status changes, dependent additions and terminations

Group-level changes | BEClericals@humana.com
Change of address, phone, contact information and group plan additions

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Producer support

Humana Business Services
Claim, benefits, billing/enrollment and web

Medical, dental and vision | 1-800-592-3005 | SBMarketSupport@humana.com

CenterWell Pharmacy® mail order | 1-800-379-0092

Humana Business Web Support | 1-888-666-5733, option 3 for employers or 4 for agents

Agency Management | **phone 1-855-330-8128** | **fax 1-920-339-2160** | agencymgt@humana.com
Commissions, licensing, agent of record and contracting
Contracting | POContracting@humana.com

Eligibility

Employee

Eligibility requirements

An employee is a person working in an active status at the employer's place of business. Active status means the employee is performing all of his or her customary duties regularly for the required hours per week shown on the Employer Group Application (EGA).

Employees who apply for coverage must also meet Humana's definition of an eligible employee. This includes the following individuals:

- U.S. citizens working outside of the United States. The total cannot exceed 30% of the entire group.
- An employee must be a U.S. citizen. If the employee is not a U.S. citizen, but they hold a green card or visa and meet Humana's definition of an active full-time employee, they are eligible for coverage.

Independent contractor eligibility (1099 employees)

We do not accept groups of 100% independent contractors. We must have at least one employee on a Wage and Tax Statement. Independent contractors are not eligible unless they are working exclusively for the employer group.

Waiting periods/probationary periods

The maximum waiting period for medical groups is 90 days, which begins immediately. HMO plans must select a maximum of 60 days, which begins on the first of the month. The waiting period(s) elected for a group must be the same for medical, dental, vision and lifelines of coverage.

Retiree

Retirees are allowed on all dental, vision and non-community rated medical groups; however, retiree coverage is not available to community rated medical groups. If the employer includes a retiree class, all retirees must be eligible for coverage. The group must meet the case size minimum of active enrollees prior to being able to add a retiree class:

Medical: Retiree coverage is available to all non-community rated medical groups regardless of case size.

- The minimum age for retiree eligibility is 50
- The employer can select the number of years of service
- Some state-specific rules may apply
- LFP: A retiree class can be set up if the group has 51 or more active full-time employees enrolling for medical coverage

Dental and vision: Retiree coverage is an option available for companies of two or more active employees enrolling. There must be at least two active enrolled lives (not retirees) in addition to the retirees in order for the group to be eligible for a retiree class.

- The minimum age for retiree eligibility is 50
- The employer can select the number of years of service

Dependents

An eligible dependent is an employee's spouse or married or unmarried children.

Spouse

The lawful spouse (legally recognized spouse) of an employee is eligible for coverage if:

- The employee meets the eligibility requirements of the policy, and
- He/she remains the legally recognized spouse of the insured employee.
- Includes domestic partner, member of civil union, common law marriage or designated beneficiary, or legally recognized same-sex spouse.

For additional questions on the details of domestic partner, civil union or designated beneficiary, please contact your Humana sales representative.

Dependent children

A dependent is defined as a natural blood-related child, stepchild, legally adopted child or child placed with the employee for adoption, or child for which the employee has legal guardianship or children of a common law spouse whose age is less than the limiting age.

- A dependent can be married (dependent's spouses, domestic partners, civil unions and/or children are not covered unless legislated by the state);
- The dependent maximum eligibility age is 26, with the exception of the following states:

State	Age	Special requirements
Florida	30	Yes, through the calendar year they turn age 30 for medical (fully insured) and dental and/or vision.
Illinois	30	Yes, unmarried military veteran dependent children who are IL residents and under the age of 30 for medical, dental, life and vision but NOT Level Funded medical
Nebraska	29	Yes, dependent children through age 29
Wisconsin	27	Requires insurers to offer coverage for dependent adult children until their 27th birthday for medical (FI and LFP), dental, and vision coverage. Not all dependents are eligible, please reach out to Underwriting with specific questions on eligibility.

Underwriting guidelines

Renewals

Renewal notifications are sent to the agent and employer at the time of the employer's renewal.

Renewals delivered

- Agent of Record is emailed a renewal notification generally 75 days in advance of the effective date, with a link to the renewal letter
- Employers are mailed their renewal notification generally 65–70 days prior to the effective date

Where to obtain renewal information

Additional renewal information is available to the agent on the secure portal at **Humana.com**:

- Employer Benefit Center (EBC)
- Benefit Utilization Director (BUD) illustrates how employees utilize benefits.
  You can view how often employees:
  - Visit their doctors – participating and non-participating physicians
  - Purchase prescription drugs
  - Meet deductibles and out-of-pocket maximums

In addition, it allows you to create a customized packet of information about benefit usage prior to meetings with your clients.

Health Plan Guide

The Health Plan Guide is an informational packet automatically sent directly to employers twice a year. It is a summary of information that you can access through the BUD. It provides the employer an overview of the benefit utilization of their plan benefits. The Health Plan Guide is located in the secured agent section at **Humana.com**.

This packet is sent to the employer:

- Two months prior to the renewal
- Six months after their renewal

Effective dates

Medical and specialty: Groups must have a first of the month effective date. (No exceptions)

Life—Dependent Delayed Effective Date:

The dependent's effective date of coverage is delayed if the dependent is:

- Confined to a hospital or qualified treatment facility
- Receiving home healthcare or hospice benefits
- Not actively at work (applicable only to dependent spouse)

The dependent's coverage becomes effective on the day after:

- Discharge from confinement (discharge must
  be certified by a qualified practitioner)
- A qualified practitioner certifies that home healthcare is no longer needed

If dependent coverage is in force or applied for within 31 calendar days of a newborn's date of birth, the Dependent Delayed Effective Date provision does not apply to the newborn child on the child's date of birth.

Group split/spin-off

If a group effective with Humana chooses to split or spin off a portion/division of the group, the following requirements are needed:

- Employer Group Application (EGA)
- New business quote
- Humana List Enrollment, to include disability question and status of employees
- Applications for new employees requesting life insurance over the guarantee issue amount
- Health status questions may be required as follows:
  - Requested life amount greater than the guarantee issue amount (GIA)
  - Late employee(s) for life on a contributory group
- HSA Employer Election Form (if group has a HSA)

If the group is part of a controlled group, the group is not eligible for a group split or spin-off.

Common control

Common control is the consolidation of control among two or more businesses governed by one individual (or group of individuals) in accordance with a contractual arrangement, based on Internal Revenue code. **Groups under common control will have their counts combined.** Employers with questions on common control should reach out to their tax advisers for advice. The count may be based on payroll, full-time equivalent or eligible as determined by state legislation.

Carve-outs

(Offering coverage to a specific class of employees) These are the standard carve-out guidelines:

State	Line of coverage	Carve-outs allowed
FL, TX and WI	Medical 1–50	Union/non-union only
All states other than FL, TX and WI	Medical 1–50	Salaried/hourly Management/non-management Union/non-union
All states	Medical 51–100	Salaried/hourly Management/non-management Union/non-union
All states	Specialty 2–99	Salaried/hourly Management/non-management Union/non-union
FL, TX and WI	Medical 1–50	Union/non-union only

All states other than FL, TX and WI	Medical 1–50	Salaried/hourly Management/non-management Union/non-union

Leasing, employment and temporary agencies

Leasing, employment and temporary agencies are eligible for coverage. Follow normal eligibility requirements. Humana reserves the right to request additional eligibility information on a case-by-case basis.

Professional Employer Organization (PEO)

PEOs are eligible for coverage. This would include all members of the PEO, administrative staff of the PEO, companies using the PEO services and/or companies breaking away from a PEO. Follow normal eligibility requirements. Humana reserves the right to request additional eligibility information on a case-by-case basis.

Startup groups

Startup companies are groups that haven’t been in business long enough to file a quarterly Wage and Tax Statement. Startup companies are eligible for coverage.

Underwriting

Community rated medical

Affordable Care Act (ACA) open enrollment

The ACA mandates an annual group Open Enrollment Period; however, Humana has made a business decision to honor this year-round. This means Humana will not check participation or contribution levels for community rated medical plans.

Case size

Community rated groups have counts of 1–50. The count may be based on payroll, full-time equivalent or eligible as determined by state legislation.

Eligibility

Employer eligibility

Employers that average 1–50 employees on business days during the preceding calendar year and employ at least one on the first day of the plan year, are considered eligible employers.

The employer must be able to verify an employer/employee relationship

- Group participation levels and employee eligibility must be verifiable through company records.
- Humana must be the exclusive health plan provider for employers.
- There must be at least one employee on the state Wage and Tax Statement. State specific guidelines may apply.

NOTE: Humana reserves the right to request eligibility information as it deems appropriate.

Small group medical eligibility

Humana does not accept small medical groups if all the enrolling subscribers of a wholly owned business consist of:

- The business owner and/or
- The business owner's spouse (opposite sex or same sex)

Texas is the only state that allows coverage for an owner and spouse group; however, both must meet the requirement of an eligible employee.

Husband and wife groups in Louisiana are acceptable if both the husband and wife meet the eligibility requirement of an eligible employee and work for the company.

Group qualifications: Guarantee access

Employers with 1–50 employees that meet underwriting eligibility are guaranteed access to all available small-business medical products. Specialty products require a minimum of two enrolled employees.

Determination of case size includes any individuals employed by an employer to include full-time, part-time, temporary and seasonal employees; however, it does not include retirees, COBRA/state continuation or independent contractors (1099). It also includes all employees of any commonly held companies who are eligible to file a combined tax return, regardless of which companies are to be included for coverage.

Contribution requirements

The employer is required to financially contribute toward the cost of the group insurance program to ensure they have a vested interest in providing insurance coverage to their employees. (Please note that contribution percentage will not be enforced.) State-specific rules may apply.

- **Non-contributory:** Employer pays **ALL** the cost of the employees' premium.
- **Contributory:** Employees must pay a **PORTION** of their premium.

Multiple-choice product options

Multiple-choice is available for the following group sizes based on the requirements by state:

- 1–4 enrolled lives: one medical plan only
- 5–9 enrolled lives: two medical plans
- 10–100 enrolled lives: four medical plans
  - Texas groups can select up to four medical plans for case size 1+
  - Georgia groups can select up to two medical plans for case size 1–4 if one of the medical plans is an HMO

Groups may multi-choice two medical plans as long as one of the plans has one of the following differences:

- Deductibles/out-of-pockets
- Coinsurance percentage levels (i.e. 100/70 and 80/50)
- Office visit copays

Multi-choice is NOT allowed between same plans with the only difference being the networks or Rx networks (except for Knoxville and Memphis markets).

Different plan generations

- A group cannot mix an old and new generation of products
- If the group is dual optioned and wants to add another plan of a new generation, they must change their current plan to the new generation plan also.

There may be other limitations. Please reach out to your sales executive with specific questions.

Multiple locations

All community rated groups are rated under the home or main office location.

Participation requirements

Participation will not be validated.

Non-community rated medical

Case size

Non-community rated groups have counts of 51 or more. The count may be based on payroll, full-time equivalent or eligible as determined by state legislation. (All Level Funded groups are considered to be non-community rated, regardless of case size.)

Contribution requirements

Contribution percentage will not be enforced.

Multiple-choice product options

Multiple-choice is available for the following group sizes based on the requirements by state:

- 1–4 enrolled lives: one medical plan only
- 5–9 enrolled lives: two medical plans
- 10–100 enrolled lives: four medical plans
  - Texas groups can select up to four medical plans for case size 1+
  - Georgia groups can select up to two medical plans for case size 1–4 if one of the medical plans is an HMO

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Different plan generations

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There may be other limitations. Please reach out to your sales executive with specific questions.

Multiple locations

Non-community rated groups will be rated using a main location (home office) and working locations for all other locations. Working locations that are in an exit state will be included under the home office location.

Please contact your sales executive with any questions regarding multiple locations.

Participation requirements

Humana will no longer enforce participation requirements.

Level Funded Premium

Case size

Level funding is an alternative to Community Rating for small employers since it offers the protection of fully insured coverage with the benefits of self-funding. Groups must meet the number of minimum enrolled count of 5.

Eligibility requirements

Underwriting

Groups requesting LFP quotes will follow all the non-community rated requirements. Exceptions include the information below.

Ineligible SIC codes

Groups with the following SIC codes are not eligible for LFP:

SIC code	Industry
7361	Employment agencies
7363	PEO, employee leasing service and temporary help service
8062–8069	Hospitals
8661	Religious organizations
9111–9199	Public administration
9221–9224	Public administration
9311–9721	Public administration

Multiple choice

Multiple-choice is available for the following LFP group sizes based on:

5–9 enrolled: dual choice is available

- Groups can dual choice with the same benefit design for both the Chamber and non-Chamber when there are employees outside the Chamber location
- No exceptions to allow more than 2 plans

10+ enrolled:

- Triple choice is available
- No exceptions to allow more than 3 plans

Different plan generations:

- A group cannot mix an old and new generation of products
- If the group is dual optioned and wants to add another plan of a new generation, they must change their current plan to the new generation plan also

Multi-choice is NOT allowed between same plans with the only difference being the networks or Rx networks (except for Knoxville and Memphis markets).

Participation requirements

Humana will no longer enforce participation requirements.

Contribution requirements

The minimum employer contribution for LFP plans is 50%.

Dental

Case size

Groups with 1–99 enrolled are eligible for dental coverage.

Eligibility

Groups with SIC code 8021 (offices and clinics of dentists) are not eligible for dental coverage.

Contribution requirements

Humana does not enforce contribution requirements for dental plans.

Participation requirements

Employer-sponsored dental

- Requires 2+ eligible with a minimum of one enrolled if sold with another line of coverage or standalone along with 50% participation after valid waivers are removed.
- Groups unable to meet the 50% participation requirement are required to enroll in a voluntary plan.

Voluntary dental

- Voluntary dental requires 2 (or more) eligible but can have a minimum of 1 enrolled employee.

NOTE: Once it has been determined at enrollment if the group will be enrolled in an employer-sponsored or voluntary plan, they will remain on this plan and will not be switched at renewal.

Waiting periods

Enrollment Type	Group Size	Prev.	Basic	Major[1]	Orthodontia[1]
Employer sponsored initial enrollment, open enrollment, and timely add-on	2-4 enrolled employees	No	No	12 months[2]	24 months[2]
Employer sponsored initial enrollment, open enrollment, and timely add-on	5 or more enrolled employees	No	No	No	No
Voluntary initial enrollment, open enrollment and timely add-on	2-9 enrolled employees	No	No	12 months[2]	24 months[2]
Voluntary initial enrollment, open enrollment and timely add-on	10 or more enrolled employees	No	No	No	12 months[2]
Late applicant[3, 4]	2 or more enrolled employees	No	No	12 months	12 months (24 months for 2-9 enrolled employees)

[1] Preventive Plus does not cover major and orthodontia services.

[2] Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.

[3] Late applicants not allowed with open enrollment option.

[4] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

Dual-choice product options

Dual-choice is available for employers with 10 or more enrolled employees

- 10–24 enrolled – 2 dental plans*
- 25–99 enrolled – 3 dental plans

***Exception:** Beta Health Alpha Dental plans are eligible to enroll in two dental plans when the group's enrolled count is 5–24.

Dual choice is available within the same product selection if the coinsurance and/or an annual maximum differs. Launch My Group has been updated to allow for this.

All TRP, PPO, and Prev+ options being included must be part of the same product generation. As long as the coinsurance and/or annual maximum differs, U&C and INFS can be distinct for each option.

The new PPO2/Traditional Preferred 2 plans can be multi-choiced amongst themselves or in combination with the existing 2019 generation plans.
Examples:

- A Traditional Preferred (TRP) 100/80/50 with a TRP 100/90/60 is acceptable.
- A TRP 100/80/50, $1,000 annual max with 100/80/50, $2,000 annual max is acceptable.

DHMO and DEPO dual choice

- DHMO or DEPO plan cannot be dual optioned with another DHMO or DEPO.
- We can allow dual option of DHMO or DEPO with either a Dental PPO or a Traditional Preferred Dental plan.

Dental rider rules—Orthodontia and implants

- If selecting orthodontia as a benefit, it is not required to have the rider on all plans. However, if you do select orthodontia, the same orthodontia plan must be used for all options. For example: A group cannot dual option a $1,500 child orthodontia rider with another plan with a $1,000 child/adult orthodontia rider.
- When selecting plans to dual choice, the only difference cannot be with ortho and without ortho, the underlying plans must at least have a coinsurance difference and/or an annual maximum difference.
- A plan with orthodontia and/or implants can be dual optioned with a Preventive Plus plan.
- Preventive Plus can be offered with a richer plan that includes orthodontia and/or implants.

All other riders

- When requesting two plans, the funding type (employer-sponsored or voluntary) for both plans must be the same for all plans.
- This is not an all-inclusive list. Please contact your Sales Executive for additional details.

Vision

Case size

Groups with 1–99 enrolled are eligible for vision coverage.

Contribution requirements

Humana does not enforce contribution requirements for vision plans.

Participation requirements

Employer-Sponsored

- **1+ group size (enrolled) written with medical and/or dental**
  - Participation is either 50% or one enrolled employee—whichever is greater
  - Groups not able to meet these participation requirements must enroll in a voluntary plan
- **5+ group size (enrollment) written stand-alone**
  - Participation is either 50% or five enrolled employees—whichever is greater
  - Groups not able to meet these participation requirements must enroll in a voluntary plan

Voluntary

- 1+ group size (enrolled) written with medical and/or dental:
  - A minimum of one enrolled employee is required
- 5+ group size (enrolled) written standalone:
  - A minimum of five enrolled employees is required

NOTE: Once it has been determined at enrollment if the group will be enrolled in an employer-sponsored or voluntary plan, they will remain on this plan and will not be switched at renewal.

Dual choice product options

We will allow a group to dual option two vision plans if the group has a minimum of 10 eligible and enrolled lives.

Vision may be dual choice if all the following requirements are met:

- Both plans must be the same type of plan (Humana Vision or Humana Vision PLUS.)
- Plans must include frame allowances at least two benefit levels apart (to be written as 100 with 150/160/200; 130 with 160/200; 150 with 200)
- Any full-coverage vision plan (i.e., Humana Vision 100, 130, 150, 160 or 200 or Humana Vision PLUS 100, 130, 150, 160 or 200) may be dual choice with a Humana Vision Exam Plus.
- Standard participation rules apply

Life

Case size

Groups with 2–99 enrolled are eligible for life coverage.

Contribution requirements

The employer is required to financially contribute toward the cost of the group insurance program to ensure that they have a vested interest in providing insurance coverage to their employees.

State-specific rules may apply.

- **Non-contributory:** Employer pays **ALL** the cost of the employees' premium.
- **Contributory:** Employees must pay a **PORTION** of their premium.

Contribution requirements: 50%

Participation requirements

Basic Life:

Employer-sponsored

- **2+ non-contributory – Requires 100% participation**

Contributory

- **2+ group size written with medical or dental:**
  - Participation is either 50% or two enrolled employees—whichever is greater
  - Groups not able to meet these participation requirements must enroll in a voluntary plan
- **5+ group size written stand-alone:**
  - Participation is either 50% or five enrolled employees—whichever is greater
  - Groups not able to meet these participation requirements must enroll in a voluntary plan

Voluntary Life

- A minimum of five enrolled is required
- Employees have the opportunity to increase their voluntary life coverage by $25,000 every year at renewal (without Evidence of Health Status), even if they exceed the guarantee issue amount

Disability

Case size

Groups with 2–99 eligible employees

Contribution requirements

Non-contributory: Employer pays all the cost of the employees' premium.

- Tax Choice: the employer has the option to provide their employees with a non-contributory, yet potentially non-taxable benefit, depending upon whether an employee elects to have the cost of coverage included in their current income and subsequently becomes disabled in the same plan year for which the election is in effect, similar to an employee-paid plan.
- Gross up: employers pay for disability premiums through post-tax employee payroll deductions and add the equivalent premium amount to the employee's taxable pay.

Contributory: Employees must pay a portion of their premium.

- Tax Choice: the employer has the option to provide their employees with a non-contributory, yet potentially non-taxable benefit, depending upon whether an employee elects to have the cost of coverage included in their current income and subsequently becomes disabled in the same plan year for which the election is in effect, similar to an employee-paid plan.
- Gross up: employers pay for disability premiums through post-tax employee payroll deductions and add the equivalent premium amount to the employee's taxable pay.

Voluntary: Employees must pay all their premium.

Participation requirements

Non-contributory

- 2+ non-contributory – Requires 100% participation

Contributory

- 10+ group size
  - Participation is either 25% or 4 enrolled lives – whichever is greater

Voluntary

- 10+ group size
  - Participation is either 25% or 4 enrolled lives – whichever is greater

Quoting

Community rated medical

Quote requests

Community rated groups seeking medical coverage can create a quote at **Humana.com** under the secured agent section. All community rated groups are quoted as single site. The count may be based on payroll, full-time equivalent or eligible as determined by state legislation. A new interactive PDF describing how to use online quoting functionality is available for agents to view at **Humana.com/ads/onlinequoting**. Please contact Easy Rate to obtain a quote for groups with two or more eligible and one enrolling.

If the business is wholly owned by one individual (and not a partnership), then at least one employee who is not the owner or spouse of the owner must enroll in the medical plan. Partnership-only groups are not eligible.

Methods to quote

- For groups that are not currently with Humana, email easyrate@humana.com

Information you'll need to quote companies with 1–50 employees

- Broker/agent Tax ID, Social Security number or Humana Assigned Number (HAN)
- Name, address and phone number of employer
- Payroll count/Average Total Number of Employees (ATNE) or full-time equivalent or eligible (based on state requirement)
- Eligible count
- Requested plan(s): Provide specific names of products you want quoted
- Nature of business and standard industry code (SIC)
- Number of COBRA employees, if applicable
- Requested effective date
- Email address for quote delivery

Member information

- Gender
- Age or birth date
- Coverage type (single, family, employee with children, employee with spouse and waivers)
- Salary data requesting a salary plan for Life products
- Medicare eligibility

Dependent information—Required at quote time

- Spouse and dependent children
- Age/date of birth
- Gender
- Medicare eligibility (for spouses)
- Dependent status

Non-community rated medical

Baseline quote requests

The count may be based on payroll, full-time equivalent or eligible as determined by state legislation. A new interactive PDF describing how to use online quoting functionality is available for agent to view at Humana.com/ads/onlinequoting. Please contact Easy Rate to obtain a quote for groups with only one enrolled medical life.

Methods to get a quote

- For groups that are not currently with Humana, email easyrate@humana.com

Information you'll need to quote companies with 1–100 employees

- Broker/agent Tax ID, Social Security number, or Humana Assigned Number
- Name, address, and phone number of employer
- Payroll count/ATNE or full-time equivalent (based on state requirement)
- Eligible count
- Requested plan(s): Provide specific names of products you want quoted
- Nature of business and standard industry code (SIC)
- COBRA and/or State Continuation, if applicable
- Number of retiree employees, if applicable
- Requested effective date
- Fax number or email address for quote delivery

Member information

- Gender
- Age or birth date
- Disability status
- Medicare eligibility
- Coverage type (single, family, employee with children, employee with spouse and waivers)
- Salary data if requesting a salary plan for Life products

Dependent information

- Spouse—Age/date of birth and gender, disability status, Medicare eligibility—Not required at baseline quote time
- Dependent—Age/date of birth, gender, and dependent disability status—Not required at baseline quote time

Multiple locations

Multiple business locations

- If quoting a company with more than one business location, provide the location, city, state and ZIP code for each location
- The census must provide location information for all employees

Underwritten quote requirements for 10 or more enrolled for non-community rated and Level Funded Premium

Groups with 10 or more enrolled subscribers must provide a detailed census in order to receive an underwritten quote.

Group information

- The group's last renewal letter (groups not required to provide a renewal letter include Virgin or startup groups, groups considered to be community rated, and groups currently enrolled with a PEO or Association).

Census requirements are:

Member information

- First and last name
- Gender
- Date of birth (age is not acceptable)
- Coverage type (single, family, employee with children, employee with spouse and waivers)
- Salary data if requesting a salary plan for Life products
- Coverage type (EE, EE+SP, EE+CH, FAM)

Dependent spouse information

- First and last name
- Gender
- Date of birth (age is not acceptable)
- Home ZIP

Dependent children information

- First and last name(s)
- Gender
- Date of birth (age is not acceptable)
- Home ZIP code (all dependent children)

Employee-level underwriting 1–9 enrolled for non-community rated and Level Funded Premium

Groups that have fewer than 10 enrolled subscribers must submit individual employee health questions. In addition to what is required at baseline quote time, the following information must be provided:

Group information

- The group's last renewal letter (groups not required to provide a renewal letter include Virgin or startup groups, groups considered to be community rated, and groups currently enrolled with a PEO or Association).

Member information

- First and last name
- Age/date of birth
- Gender
- Coverage type
- Social Security number (optional)
- Total disability and medical questions

Dependent information

- First and last name
- Age/date of birth
- Gender
- Total disability and medical questions

Specialty

Quote requests

Companies of 2–99 employees seeking specialty coverage can create a quote at **Humana.com** under the secured agent section. Specialty-only lines of coverage will follow the same community rated and non-community rated guidelines based on their counts. A new interactive PDF describing how to use online quoting functionality is available for agents to view at **Humana.com/ads/onlinequoting.**

Other methods to get a quote

- For groups that are not currently with Humana, email easyrate@humana.com
- For existing groups already with Humana, email conservation@humana.com

Information you'll need to quote companies with 2–99 employees

- Broker/agent Tax ID, Social Security number, or Humana Assigned Number (HAN)
- Name, address and phone number of employer
- Eligible count
- Requested plan(s): Provide specific names of products you want quoted
- Nature of business and standard industry code (SIC)
- Number of COBRA employees, if applicable
- Requested effective date
- Fax number or email address for quote delivery

Member information

- Gender
- Age or birth date
- Coverage type (single, family, employee with children, employee with spouse and waivers)
- Salary data if requesting a salary plan for Life products
- Salary mode (weekly, biweekly, annual, monthly, hourly, etc.)

Spending accounts

All Humana Access Spending Accounts are available to quote for any group size. Employers can feel confident in providing spending accounts that are competitively priced, flexible and easy to administer.

Members can more easily manage their accounts through one debit card and our dedicated mobile-friendly Spending Account website.

Requirements

All Humana Access Spending Accounts are available to all case sizes when sold with a Humana medical plan.

Member must be enrolled in a Humana high-deductible medical plan in order to enroll in a Health Savings Account.

For all spending accounts, Launch My Group or the Employer Election Form (EEF) must be completed (the EEF can be found here.

Health Savings Accounts (HSA)

HSAs can only be offered with the Humana Savings HSA, an IRS-qualified high-deductible health plan (HDHP) and allow employees to save for eligible healthcare costs through a pre-tax payroll deduction, while earning interest on funds saved.

Health Reimbursement Arrangements (HRA)

HRAs are funded by the employer, are not taxable, and help employees pay for eligible healthcare costs. HRAs can be offered with any health plan. If paired with the Humana Savings HSA health plan and HSA, the HRA must be post-deductible.

Healthcare Flexible Spending Accounts (FSA)

FSAs can be offered with any health plan and the annual contribution is available the first day of the plan year for eligible healthcare expenses. Contributions are a pre-tax payroll deduction.

Limited Purpose FSA

Extended pre-tax savings for dental and vision eligible expenses. Combine with HSAs to help employees save specifically for vision and dental expenses. Contributions are a pre-tax payroll deduction.

Dependent Care FSA (DCFSA)

The DCFSA allows employees to save for eligible dependent care expenses so they can work. Contributions are a pre-tax payroll deduction.

Rate card

To view the full flyer and rate card, click here.

Spending accounts-existing business

Quote requests

All quote requests must be requested by a Humana Account Manager or the group's current Agent of Record. Groups currently enrolled for coverage with Humana can request alternate quotes for their current plans on renewal, or they can request quotes off renewal when the group adds new lines of coverage. For all off-renewal requests on existing lines of coverage, please contact your Retention Executive.

Groups requesting to add a new line of coverage can receive a quote at any time.

Alternate quotes can be obtained by:

- Emailing conservation@humana.com
- For existing Level Funded groups requesting LF quote, email to levelfunding@humana.com
- Contacting your Retention Executive

Please include the following information when requesting an alternate quote:

- Group name
- Group number
- Lines of coverage
- Detailed plan information to be included in the quote
- Requested effective date
- Census if additional employees are to be included
- Salary data requesting a salary plan for Life products

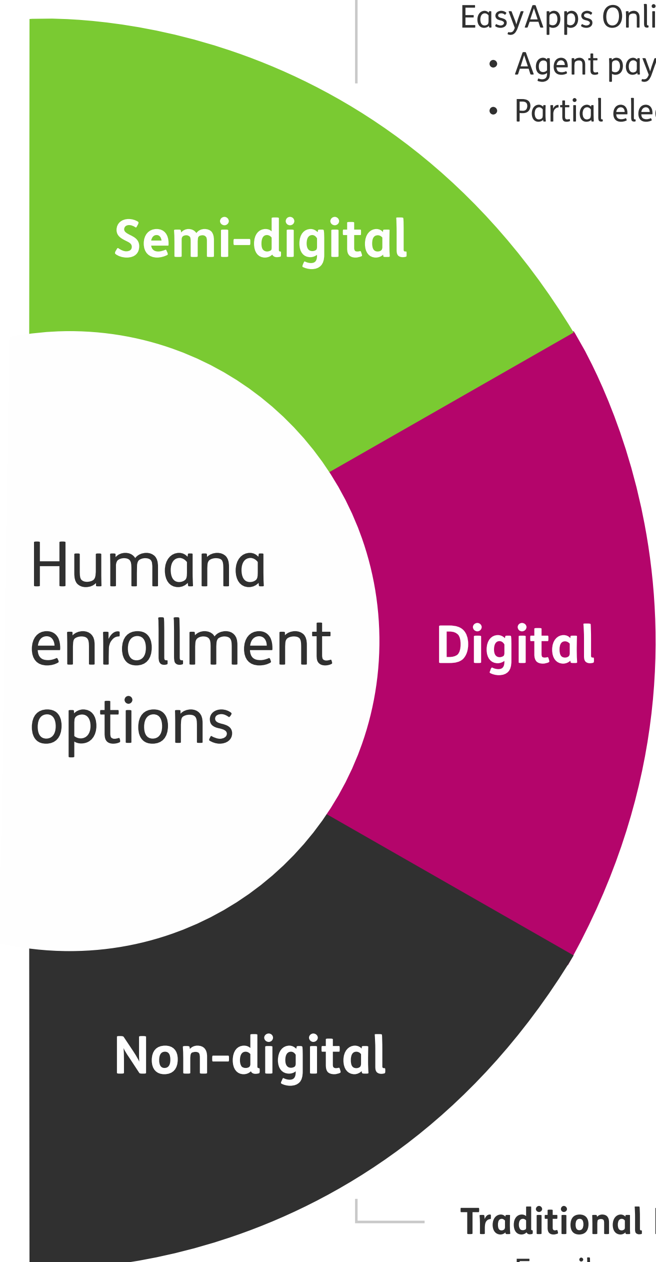
Employer Benefit Center (EBC)

The EBC is a resource available to groups with 2-99 members that allows Employers to view membership, current plans and rates throughout their plan year as well as renewal data once their renewal has been completed. A newly enrolled group will not be able to view their data in the EBC until the new case effective date is reached. There may be times when a particular group is not available on the EBC. If a group is not displayed in the EBC, contact your Retention Executive or Conservation to obtain a quote.

Groups can view their upcoming renewal in the EBC.

- Groups can view their renewal through the EBC starting 75 calendar days prior to the renewal date through the effective date of the renewal. The My Renewal Plans page no longer displays after the calendar renewal effective date. At that time, it displays the group data on the My Current Plans page.
- Requests to obtain a quote to add new lines of coverage must be requested from your Retention Executive or Conservation.
- Census changes cannot be made through the EBC. The employer can either submit the changes through the employer portal or through Billing and Enrollment.

New group enrollment options



Employee Enrollment Vendors

EasyApps Online, FormFire, UBenefit, E-healthApp, PlanSource

- Agent pays fee to the vendor
- Partial electronic experience

Connected Technology Partners

- Transform the client's experience
- Total electronic experience using a digital or mobile platform
- Agent pays a fee to vendor
- Vendor provides training and support
- Humana will add more partners over time

Launch My Group

- Transform the client's experience
- Total electronic enrollment experience
- No cost to groups or agents
- Access through **Humana.com**
- Link to Agent User Guide

Traditional Enrollment

- Email enrollment documents to Humana
- No cost to groups or agents

New group enrollment requirements

Humana highly encourages the use of Launch My Group in lieu of an email submission for new group coverage. The submission through Launch My Group ensures the correct documents are created for signature, minimizes the up-front submission requirements, and eliminates the need to collect missing information. The average turn around for a group submitted through Launch My Group is 1-2 business days even during the peak open enrollment season. To access Launch My Group, you will need a final, complete (including underwriting, if required) quote. Once you access Launch My Group, a list enrollment based off the final quote and group plan selections will be provided for completion and upload. Upon clicking submit, the Employer Group Application will be created and delivered for electronic signature based on the information provided. Please see the Agent Guide for more information regarding Launch My Group enrollment.

When submitting a new group enrollment via email, the enrollment materials must be submitted to your sales representative, sbsales@humana.com, or via secure email no later than the 5th calendar day after the requested effective date. (Click here for instructions on how to send enrollment information via secure email.)

Humana requires the following information for enrollment:

- **Most recent version of the Employer Group Application (EGA).** Please be aware that multiple applications may be required based on line(s) of coverage sold, plans sold and group size. (CA, CO, MD, MT, MO, NE, NY, OH, TX, UT, VA). The EGA must be signed prior to the requested effective date.
- **Most recent version of the employee enrollment forms** with medical information based on case size as specified on the application. Please be aware that multiple applications may be required based on line(s) of coverage sold, plans sold and group size. (CA, CO, MD, MT, MO, NE, NY, OH, TX, UT, VA)

OR

- **Humana-approved List Enrollment obtained from Humana.com.** The List Enrollment is valid for community rated medical in all states except CO and UT, and for all specialty groups (except SD) and non-community rated groups.

State	1–50 (Medical with dental, life, vision) *	51+ (Medical with dental, life, vision) *	2–100 specialty only (Dental, life, vision) *
SD	N/A – medical exit state		No
All other states	List Enrollment can be used to enroll all lines.		

*Life is 2–99

- **Waivers (either provided on applications or indicated on the Humana-approved List Enrollment)** must be completed and submitted for employees not electing coverage for themselves or their eligible dependents if it is required by the state. If List Enrollment is submitted in lieu of applications, waivers must be included. Waiver forms are not required for voluntary dental and life coverage. In lieu of waiver forms, the employer must submit a letter stating all eligible employees had the opportunity to enroll.

- **The final quote version** which illustrates the sold plans, in which the employer is enrolling. Cases submitted without a valid sold quote are returned for updating.
  - All cases—The final quote version must be free of assumptions
  - Non-community rated fully-insured medical and all Level Funded Premium plans—A fully risk-rated/underwritten quote is required

New group enrollment requirements

- **Multi-location information** – If the sold group is Level Funded Premium or 51+ Fully Insured, the group may be multiple location based on Humana's business rules. Provide the working locations identified on the quote along with the employee(s) in each location.

- **Humana Health Savings Account Employer Election form**, if applicable

- **NPOS Disclosure form**, for all NPOS groups sold in Texas

Cases may be returned during the review process if:

- Incorrect applications are submitted, or List Enrollment is utilized when not allowed.
- The group is determined to be non-community rated and the submitted case is community rated (non-underwritten quote, incorrect product, no medical information provided).
- Agent of Record or Writing Agent does not have a current, valid license and contract with Humana prior to the requested effective date.
- Master application is signed or dated after the requested effective date.

Cases requesting missing information must have the information returned within five business days. Cases that do not return the requested information in the allotted time are closed out/withdrawn. Additional medical information may be requested by Underwriting upon review of the case. Incomplete submissions may delay processing of the group's application. Humana cannot approve coverage until all completed enrollment requirements are met.

For the most current forms, access **Humana.com** or contact your sales representative to discuss options.

Billing

Premium billing

Invoices are generated around the 15th day of the month and recurring electronic invoices are generated on the 20th day of the month preceding the month of coverage. Premium payments are due on the first day of the applicable coverage month. A monthly administrative fee may be charged on medical products for group sizes 2–99, and fee amounts may vary by state. If premium due is not received by the 15th of the month, the group receives a reminder letter/email informing them premium has not been received. If premium due is not received by 31 days after the due date, the group is terminated and receives a termination letter explaining our termination and/or reinstatement procedures. Registering in the agent section of **Humana.com** enables you to view the groups' premium billing statements and online payment history. In addition, you can view the late payment notifications that your groups might have received.

e-billing

Groups can take advantage of the following benefits in e-Billing:

- Download billing details into a report format
- View a PDF of invoice (18 months)
- Make a one-time payment or schedule a recurring payment
- Review payment history

Groups can take advantage of e-Billing notifications such as:

- Past due premium
- Invoice available
- Payment received
- Returned payment
- Schedule payment reminder
- Payment due reminder

Invoiced vs Paid Reporting

To make it easier for employers to pull together information that may be required for review, they can use this tool available online called "Invoiced vs. Paid". This report will show monthly invoiced insurance premiums and payments received for the last 24 months from the current date.

How to pull an Invoiced vs. Paid Report

- Visit the Employer Portal to sign in or register
- Choose "Go to Billing"
- On the "Invoice Summary" page choose the excel link "Invoiced vs. paid"

Payment Options

Humana offers many payment options to our groups and members, which includes:

- Online payments - using a checking or savings account
  - By signing into their account on **Humana.com**
  - Using Express Pay, which is a quick and way to make a payment without logging into their account.
- Paying by phone - using a checking or savings account
- Via paper check

Group maintenance

New hires, changes and terminations

Open enrollment

Open enrollment typically occurs on an annual basis. The standard duration of open enrollment is 91 days. The OE period start date begins 60 days before the OE effective date and ends 31 days after the OE effective date. During this time, eligible employees and dependents can enroll for coverage under the group policy. Late applicants may enroll at the group's next Open Enrollment Period (OEP). Unless there is a qualifying event, eligible employees must wait until the next OEP to enroll for group coverage.

Enrolling a new employee

An enrollment form must be completed, dated and signed before the Employer Group Application can be processed.

Enrollment forms can be found in the agent section of **Humana.com.** Select the **Printable Enrollment and Change Forms** link under Customer Support for Agents. Or, if you prefer, you can order them via the agent-secured section under Market & Products by selecting the Order Marketing Material link.

New employees can be enrolled in the following ways:

- Enter the request on our easy-to-use online administrative tool at **Humana.com**, through Agent Delegation
- Email enrollment (Click here to learn how)
- Fax the enrollment form to Enrollment at **1-866-584-9140**
- Mail the enrollment form to:
  Humana Enrollment
  P.O. Box 14209
  Lexington, KY 40512-4209
- Overnight the enrollment form to:
  Humana Enrollment
  2432 Fortune Drive, Suite 120
  Lexington, KY 40509-4269

Note: Employees who want basic or voluntary life insurance for more than the guaranteed issue amount must complete an Evidence of Health Status form and the Life Authorization form. Underwriting may request additional information upon review.

Timely applicant

Timely applicants are any employees or dependents applying for coverage within 31 days of the eligibility date or of a qualifying event. The eligibility date is the probationary period set by the employer at enrollment or by the date the qualifying event occurs.

A qualifying event is defined as:

- Marriage or legally recognized partnership
- Adoption
- Birth of a child
- Change of legal guardianship
- Loss of prior medical, dental, or vision coverage
- Divorce

Note: For dental, a newborn is considered timely if he/she is added to the plan by his/her second birthday.

Late applicant

Any employee or dependent applying for coverage outside the OEP, or after 31 days of a qualifying event, is considered a late applicant. If the group has an open enrollment provision and a late applicant applies for coverage outside the OEP, we mail a courtesy letter to both the employer and member to notify them that the application will not be processed and to advise the member of the next open enrollment dates.

Employee coverage change

Employers can make employee coverage changes by submitting an Employee Change form. Agents can also make the change through the secured agent section of **Humana.com** via Agent Delegation.

Life changes can result in multiple member modification requests such as:

- Adding dependents
- Adding a newborn
- Moving from one plan to another when a group offers more than one plan (done at open enrollment/renewal)
- Terminating dependents
- Decreasing coverage type (family to single, employee and spouse, or employee and children)
- Cancelling a line of coverage
- Beneficiary changes (for applicable products)

A Change Request can be submitted by:

- Faxing the enrollment form to Billing and Enrollment at **1-866-584-9140**
- Mailing the enrollment form to Billing and Enrollment at:
  Humana Enrollment
  P.O. Box 14209
  Lexington, KY 40512-4209
- Emailing enrollment (Click here to learn how)
- Enter the request on our easy to use online administrative tool through Agent Delegation, which is located in the agent-secured section of **Humana.com**.

Employee/dependent terminations

An employee and/or dependent termination occurs when an employee and/or dependent no longer is eligible for coverage. The termination date is based on the effective date provision selected by the employer—either the end of the month or immediately upon termination—as specified on the EGA.

To ensure only eligible members receive benefits, please notify Humana of any member (employee and dependent, including COBRA and State Continuation members) terminations as soon as possible via the following methods:

- Fax a change request form to **1-866-584-9140**
- Enter the request on our easy-to-use online administrative tool at **Humana.com**, through Agent Delegation
- Call Humana Business Services at **1-800-592-3005** and follow the telephonic prompts

Here are some important items to remember when processing an employee/dependent termination:

- A termination request should not be enclosed with the invoice payment
- Humana does not backdate terminations more than 60 days from the time the termination request is received, unless required by state law
- Certificate of Prior Coverage:
  - Humana provides terminated individuals notification for all medical policies
  - Humana provides terminated individuals notification for applicable specialty benefit policies upon request

Group maintenance

Medical (2-99)

A **plan-add** is defined as adding an additional line of coverage to an existing group. Adding additional products to an existing line of coverage or making benefit modifications to an existing product is considered a **plan change**.

- **On renewal, medical plan-adds and changes must be submitted 10 business days** prior to the effective date. Cases are accepted until the fifth day after their effective date if attestation form is included. The general turnaround on plan-adds and changes is five to seven business days from receipt.
- **Off renewal, medical plan changes** are due 70 days prior to the requested effective date. Changes are not available in every situation. Please contact your Humana Sales Executive.
- **Dental, vision and life plan changes** cannot be done within 90 days prior to the group's renewal.
- **On renewal, dental, vision and life plan-adds and changes** must be submitted by the fifth calendar day after the requested effective date.

Please note that inventory fluctuations or missing required documentation can impact turnaround.

Medical

Medical plan-adds

When adding a medical plan to an existing group currently without Humana medical coverage, please submit the following:

Coverage added	Documentation requirements/rules**
Adding medical coverage	• EGA • Enrollment forms or Humana List Enrollment • Waivers (required for community rated medical plans in the following states: CO, OK, TX, UT and WI) • Final quote • Summary of Benefits and Coverage Attestation form (if applicable) • Small Employer Certification for Group Medical Coverage form (if applicable) and/or Texas Small Employer Certification for Group Medical Coverage

* This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

** Disclosure for Consumer Choice NPOS and HMO form (only if group is in Texas and adding a NPOS or HMO product)

The required information and materials for a plan-add should be submitted to beclericals@humana.com.

Medical Plan Changes

When making plan changes to a Humana group's existing medical coverage, please submit the documentation listed below:

Change in coverage	Documentation requirements/rules**
Changing from one single-option product to another single-option product on renewal	• EGA • Enrollment forms or Humana List Enrollment • Waivers (required for community rated medical plans in the following states: CO, OK, TX, UT and WI) • Final quote • Summary of Benefits and Coverage Attestation form (if applicable) • Small Employer Certification for Group Medical Coverage form (if applicable) and/or Texas Small Employer Certification for Group Medical Coverage
Changing from one single-option product to another single-option product off renewal	• Group Maintenance Request Form or EGA • Final quote • Subject to Underwriting approval • Movement from non-HDHP product to Savings HSA high deductible health plan is prohibited
Changing from a single or multiple option to multiple options on renewal	• Group Maintenance Request Form or EGA • Final quote • Membership Assignment (if applicable) • Attestation form (if applicable) • Enrollment forms or a list enrollment (preferred) spreadsheet for members with product selection
Changing from a single or multiple option to multiple options off renewal	• Group Maintenance Request Form or EGA • Final quote • Enrollment forms or a list enrollment spreadsheet (preferred) for members with product selection • Subject to Underwriting approval • Movement from non-HDHP product to Savings HSA high deductible health plan is prohibited

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

**Disclosure for Consumer Choice NPOS and HMO form (only if group is in Texas and adding a NPOS or HMO product)

To submit required documentation for a plan change:

- Email beclericals@humana.com

Group maintenance

Dental and vision (2-99)

Dental and vision

Dental/vision plan-adds

When adding a dental or vision plan to an existing group currently without Humana dental/vision coverage, please submit the documentation listed below:

Coverage added	Documentation requirements/rules**
Adding dental or vision coverage	• EGA or Group Maintenance Request form • List Enrollment (preferred) or Enrollment forms and waivers • Final quote • Prior carrier information

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions. The required information and materials for a plan-add should be submitted to beclericals@humana.com.

Dental/vision plan changes

Dental plan changes cannot be done less than 90 days prior to the group's renewal. When adding a dental plan to an existing group currently without Humana dental/vision coverage, please submit the documentation listed below:

Coverage added	Documentation requirements/rules**
Changing from one single-option product to another single-option product on renewal	• Group Maintenance Request form • Final quote
Changing from one single-option product to another single-option product off renewal	• Group Maintenance Request form • Final quote (subject to Underwriting approval)
Changing from a single or multiple option to multiple options	• Group Maintenance Request form • Final quote • Enrollment forms or a list enrollment spreadsheet for members with product selection

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

To submit required documentation for a plan change:

- Email beclericals@humana.com

Life

Life plan-adds

The required information and materials for a plan-add should be submitted to beclericals@humana.com.

When adding a plan to an existing group currently without Humana Life coverage, please submit the following:

Coverage added	Documentation requirements/rules**
Adding life coverage	• EGA or Group Maintenance Request form • List Enrollment (preferred) or enrollment forms and waivers • Final quote • Evidence of Health Status and Life Authorization Form if over the guaranteed issue amount. Forms should be emailed to enrollment@humana.com

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

Life plan changes

The required information and materials for a plan change should be submitted to beclericals@humana.com

Note: If Life amount requested is over the guaranteed issue amount, consult your Humana sales associate. Life plan changes cannot be done less than 90 days prior to the group's renewal. When making plan changes to a Humana group's existing Life coverage, submit the documentation listed below:

Coverage added	Documentation requirements/rules**
Changing from one single-option product to another single-option product on renewal	• Group Maintenance Request form • Final quote
Changing from one single-option product to another single-option product off renewal	• Group Maintenance Request form • Final quote
Changing Life volume from single/flat amount to a class schedule	• Group Maintenance Request form • Final quote • List of members, their class and amounts • Subject to underwriting approval
Changing Life amounts	• Group Maintenance Request form • Final quote • Evidence of Health Status (if amount requested is over guaranteed issue)

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

Group/line of business termination

Groups may terminate coverage at any time if written notice is received before the requested termination date. All premium payments are due up to the date of termination. If the employer is moving to a new carrier, we advise the group to wait to terminate current coverage until it has approval and proof of coverage with the new carrier.

We backdate group terminations up to 60 days from date of receipt. The requirements listed below are acceptable when signed by a group contact or owner/officer for a group or division level term request.

Please notify your Humana Account Manager of all terminations.

Change in coverage	Documentation requirements/rules**
Group termination and a line of business termination (keeping a separate line of business with Humana)	• Email from group contact • Letter on company letterhead (signed by a group contact or owner/officer) • Letter on company fax sheet (signed by a group contact or owner/officer) • Email through the secure Employer Portal on **Humana.com** • Group Maintenance Form (signed by a group contact or owner/officer) • Requirements should be emailed to: beclericals@humana.com

The following table illustrates the state-specific termination rules:

Change in coverage	Termination rule
Colorado	Colorado groups cannot retroactively terminate a company termination date, unless the group has moved to a different insurance carrier. The new carrier information that must be included: • Carrier name • Phone number • Effective date • Employer group number

Demographic changes

Change in coverage	Documentation requirements/rules**
Adding a location or billing division (billing division can only be done upon renewal)	• Carrier name • Phone number • Effective date • Employer group number
Employer address change (same county); **new county, same market** – plan change will reach out for additional paperwork if benefits are determined to be unavailable in that county	• EGA • Email from group contact • Group Maintenance Request form • Letter on company fax sheet or letterhead • Web request • Call Humana's Contact Center • Requirements should be emailed to: beclericals@humana.com
Employer address change (moved to a **new state**)	• Alternate quote • EGA, based on new issue state of company • Enrollment forms, only if the company is electing a provider required plan (HMO, POS, etc.) • Requirements should be emailed to: beclericals@humana.com
Employer address change (moved to a **new market**)	• Alternate quote • EGA • Enrollment forms, only if the company is electing a provider required plan (HMO, POS, etc.) • Group Maintenance Request form • Requirements should be emailed to: beclericals@humana.com
Company contacts change	• Alternate quote • EGA • Enrollment forms, only if the company is electing a provider required plan (HMO, POS, etc.) • Group Maintenance

Probationary waiting periods

Medical

The chart below illustrates what a group may select as benefit probationary waiting period. Effective date provisions are either the first of the month following, or immediately following the probationary waiting period. The probationary period combined with the effective provision cannot exceed 90 days.

Days	Months
0	0
30	1
60	2
90	

Note: Humana applies the probationary waiting period as written on the EGA and does not assume that one month equals 30 days.

A provision of the ACA provides that, for plan years beginning on or after January 1, 2014, health plans or insurers offering group health coverage may not apply eligibility probationary periods, also called waiting periods (the length of time employees must be actively at work before becoming eligible for the medical insurance) that exceed 90 calendar days.

The effective date provision for when coverage begins after the probationary waiting period is product and state specific. However, no waiting period may be applied for medical coverage that results in a period longer than 90 calendar days before coverage is effective for eligible employees and dependents. Please see the following:

Product	Effective date provisions
All Humana plans	Either • First of the month following the completion of the probationary waiting period • Immediately following the probationary waiting period

Note: Some HMO products (traditional HMOs) with select network configuration will only be allowed to have first of the month following the completion of the probationary waiting period. Please check with your Humana sales representative for further clarification.

Product	Effective date provisions
Waiting period	• EGA • Plan Change Request form • Letter • Requirements should be emailed to: beclericals@humana.com

*This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

Dental

If a group has medical, these lines must mirror the medical probationary period. The effective date provision for when coverage begins after the probationary waiting period is product and state specific. Please see the following:

Product	Effective date provisions
Most Humana plans	Either • First of the month following the completion of the probationary waiting period • Immediately following the probationary waiting period
DHMO	

This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

Group maintenance

Open Enrollment

Open enrollment typically occurs on an annual basis. The standard duration of open enrollment is 91 days. The OE period start date begins 60 days before the OE effective date and ends 31 days after the OE effective date. During this time, eligible employees and dependents can enroll for coverage under the group policy. Late applicants may enroll at the group's next Open Enrollment Period (OEP). Unless there is a qualifying event, eligible employees must wait until the next OEP to enroll for group coverage.

Dental

Dental products with open enrollment have the ability to change the OEP, should a group request to alter the open enrollment time period. The open enrollment is an available option. A fee may be associated with the products depending on case size and product offering. Certain products, for example our DHMO product, include the open enrollment provision.

Vision

Vision products with open enrollment have the ability to change the OEP, should a group request to alter the open enrollment time period.

Product	Documentation requirements/rules
Open Enrollment Period	• Group Maintenance Request form • Quote

This chart is not all-inclusive. Please contact Humana Business Services at **1-800-592-3005** for additional info and/or questions.

Life

There is no open enrollment on life. Members who wish to enroll in life coverage more than 31 days after they are initially eligible or outside of a qualifying event are considered late applicants and must submit Evidence of Health Status in order to be considered for coverage.

Premium-only plan

A Premium-only plan (POP) is an employee benefit program that reduces employer and employee payroll taxes. By taking advantage of certain provisions of Section 125 of the Internal Revenue Code, POP can reduce the client's company's payroll, which is subject to employment taxes.

Additionally, the client's employees will reduce their taxable income by making contributions to certain employer-sponsored benefit plans, meaning they pay less federal income, FICA (Social Security and Medicare tax) and most state income taxes, increasing the client's employees' take-home pay.

Humana POP is serviced through HealthEquity (formerly known as WageWorks). The First year Implementation Fee (whether a short plan year or full 12-month term is selected) is paid by Humana. For each renewal Term, a service fee of $100.00 is billed to the group by HealthEquity. Information regarding the Fee is indicated on the POP application.

The IRS defines the products eligible under Section 125 of the IRS code as follows: A cafeteria plan is a separate written plan maintained by an employer for employees that meet specific requirements of and regulations of Section 125 of the Internal Revenue Code. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit.

Qualified benefits are those that do not defer compensation and are excludable from an employee's gross income under a specific provision of the Code without being subject to the principles of constructive receipt. Qualified benefits include:

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance)
- Adoption assistance
- Dependent care assistance
- Group-term life insurance coverage
- Health savings accounts, including distributions to pay long-term care services

Note: This information is NOT and should NOT be used as legal or tax advice

Continuation of coverage

State continuation

Employers who maintain a group health insurance plan and employ 20 or more full- and/or part-time employees during 50% of the business days in the preceding calendar year are obligated to comply with federal COBRA regulations. The employee's eligibility for state continuation is determined by the state where the company is located. Obtain specific guidelines and requirements for state continuation by:

- **Humana.com** – Employer section, Customer Support for Employers, selecting Enrollment Guide
- Call Humana Business Services at **1-800-592-3005**

Note: Continuation does not apply to life or disability products.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to employers that have had 20 or more employees during the prior 12 months. The law requires employers who maintain group coverage (medical, dental, and/or vision) to offer employees and/or their dependents continuation of group coverage at group rates when there is a loss of group insurance coverage. For COBRA-specific guidelines:

- **Humana.com** – Employer section, Customer Support for Employers, selecting Enrollment Guide
- Call Humana Business Services at **1-800-592-3005**

Note: COBRA does not apply to life or disability products.

Humana no longer has a COBRA Administrator. Each group can select their own.

Certificate of Group Health Plan coverage (COBRA and state continuation)

- Humana provides terminated individuals notification for all policies per state regulations or upon request.

Portability

Note: Portability applies to Voluntary Life products only.

Active eligible employees who leave the group can continue voluntary life insurance by paying premiums to Humana if they are not yet age 70. Only coverage in force or a lesser amount can be ported. Coverage is portable for dependents if the employee ports coverage. If the group terminates, ported coverage is eligible for conversion. In addition, portability is available only with voluntary life.

Portability does not include AD&D, waiver of premium, and accelerated death benefit.