Humana Agent Sales Guide

- For commercial group products
- Group Size 1-99

Revision: 1/1/15

Humana®

Humana Agent Sales Guide

This Humana Agent Sales Guide ("Guide") is intended as a general guideline to assist agents and is not intended to provide specific legal or regulatory requirements, which can vary based on various factors, including state and applicable product. Because state and federal laws vary, agents (employed by Humana or contracted with Humana) should be aware of and comply with applicable laws, including but not limited to state licensing laws. Agents* must be properly licensed, appointed (where applicable), contracted (if applicable), and certified (if applicable), before engaging in any agent activity, including selling, soliciting, or negotiating Humana or its wholly owned subsidiaries' (collectively, "Humana") products or services. This Guide does not amend, supersede, alter or otherwise affect an agents duties, responsibilities, or obligations under applicable laws, Humana policies and procedures, and/or terms and conditions of applicable contracts with Humana.

* The writing agent on a policy is an individual working direct with the policyholder/group. The writing agent can also be the Agent of Record (AOR) on the policy, but not in all cases. In a case where the writing agent is not the AOR, the writing agent receives payment from the AOR. In this case, the writing agent is allowed to receive plan information, but is not authorized to receive commission information (unless the writing agent is also the AOR) as he/she does not receive direct commission from Humana.

Group maintenance

New hires, changes, and terminations

Plan change: Groups size 2-99

Continuation of coverage

Who to contact

New business quotes (Easy Rate):

- Quotes by phone: 800-327-9728
- Quotes by fax: 800-344-3294
- Quotes by email: easyrate@humana.com

Quotes for in-force groups (Conservation):

- Quotes by phone: 800-327-9728
- Quotes by email: conservation@humana.com

New business submission:

Email: 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

Employee enrollment / change forms:

New hires, employee status changes, dependent adds and terms

- Fax: 866-584-9140

Group-level changes:

Change of address, phone, contact information

Group plan-adds

- Email: BEClericals@humana.com
- Fax: 877-369-5615

Agent Center of Excellence:

Claim, benefits, billing and enrollment, and web

- Medical: 800-592-3005
- Pharmacy: 800-558-4444 ext. 3378912
- RightSource Mail Order: 800-379-0092
- CompBenefits Dental & Vision: 888-692-2669

Agency management:

Commissions, licensing, agent of record, and contracting

- Phone: 855-330-8128
- Fax: 920-339-2160
- Email: agencymgt@humana.com

COBRA / Ceridian:

- Phone: 866-250-9474

General Agency (GA) log-in

HUMANA SYSTEMS LOG-IN INSTRUCTIONS

1. GA has a unique market source

General Agencies with their own unique market source: RBG, BenefitMall and Warner Pacific

1. Log into Humana systems through https://myapps.humana.com
2. Enter your Humana user ID and password and at the applications screen, click on the Humana Intranet Applications icon
3. Re-enter your Humana user ID and password, and you will be brought to Humana Self Service (HSS)
4. Once in the HSS portal, locate the link to the appropriate application

2. GA is the Agent of Record*

General Agencies who are the Agent of Record

If you have a Humana User ID and password

1. Log into Humana systems through https://myapps.humana.com
2. Enter your Humana user ID and password and at the applications screen, click on the Humana Intranet Applications icon
3. Re-enter your Humana user ID and password, and you will be brought to Humana Self Service (HSS).
4. Once in the HSS portal, locate the link to the appropriate application

If you do not have a Humana User ID and password

1. Ensure that your agency is registered on Humana.com
2. Log into the Agent Section of Humana.com
3. Locate the link to the appropriate function/application

* The Agent of Record (AOR) is the individual or company authorized to represent an insured in the purchase, servicing, and maintenance of insurance coverage with a designated insurer. The agent of record has a legal right to receiving commissions from the respective insurance policy and work with the carrier for plan changes / updates.

3. GA is NOT the Agent of Record

General Agencies who are NOT the Agent of Record, but have a 3 digit Humana General Agent identifier (GA ID):

If you have a Humana User ID and password

1. Log into Humana systems through https://myapps.humana.com
2. Enter your Humana user ID and password and at the applications screen, click on the Humana Intranet Applications icon
3. Re-enter your Humana user ID and password, and you will be brought to Humana Self Service (HSS)
4. Once in the HSS portal, locate the link to the appropriate application

If you do not have a Humana User ID and password

You will need to work with the Agent of Record through the delegation process to access Agent portal functions.

Underwriting

COMMUNITY-RATED MEDICAL

This information applies to groups with payroll counts of 50 or less.

1. Affordable Care Act (ACA) open enrollment

ACA mandates an annual Group Open Enrollment period, however, Humana has made a business decision to honor this year round.

2. Case size

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

3. Contribution requirements

The employer is required to financially contribute toward the cost of the group insurance program to ensure the employer has 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.

Humana's standard contribution requirements are:

Line of coverage	Contribution requirements
Basic Life	Non-Contributory – 100% Contributory - 50%
Disability	Non-Contributory – 100% Contributory - 50%
WVB	0%
Medical	Contribution percentage will not be enforced
Dental	Contribution percentage will not be enforced
Employer-sponsored Vision	50%
Voluntary Plans	0%

4. Effective dates

- **Medical and Specialty:** Groups must have a 1st of the month effective date. NO EXCEPTIONS.
- **Life - Dependent Delayed Effective Date:**

  The dependent's effective date of coverage will be delayed if the dependent is:
  - Confined to a hospital or qualified treatment facility or
  - Receiving home health care or hospice benefits or
  - Not actively at work (applicable only to dependent spouse)

  The dependent's coverage will be effective on the day after:
  - Discharge from confinement (discharge must be certified by a qualified practitioner)
  - A qualified practitioner certifies that home health care 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 will not apply to the newborn child on the child's date of birth.

5. Eligibility: Medical, Dental, Vision, and Life

Employer eligibility

A small employer is one who employed an average of at least one but not more than 50 employees on business during the preceding calendar year and who employs at least one on the first day of the plan year.

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 with 1 - 99 employees on payroll
- 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

One-life group eligibility

- One-life groups are acceptable for medical in all states Humana does business. In order to be eligible, the group must have at least one individual on a Wage and Tax statement.
- One-life groups are only eligible for medical lines of coverage.
- North Carolina is the only state that allows coverage for a sole proprietors or self-employed individuals as eligible groups.

Common control

Common control is the consolidation of control among two or more business. Businesses under a common control arrangement are 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. Employer with questions on common control should reach out to their tax advisors for advice. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

Group qualifications: Guarantee access

An employer with 1 - 50 employees that meets underwriting eligibility and participation requirements is guaranteed access to all available small business medical products. Specialty products require a minimum of 2 enrolled employees. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

Determination of case size includes any individuals employed by an employer to include fulltime, part-time, temporary and seasonal employees, however, 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.

Carve outs – offering coverage to a specific class of employees

These are the standard carve out guidelines.

Product line	Acceptable carve-out classes are limited to:
State-specific 1-50 payroll	FL, WI, and TX: Union / non-union only
Medical 1-99 payroll or ancillary 2-99	• Salaried / hourly • Management / non-management • Union / non-union

Leasing company / employment agency / temporary agency

Leasing, employment and temporary agencies are eligible for coverage.

Follow normal eligibility requirements including a prior carrier billing statement, when applicable.

Humana reserves the right to request additional eligibility information on a case-by-case basis.

PEO (Professional Employer Organization)

PEO's 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 including a prior carrier billing statement, when applicable.

Humana reserves the right to request additional eligibility information on a case-by-case basis.

Start-up groups

A startup company is a company that hasn't been in business long enough to file a quarterly wage and tax statement.

6. Eligibility: LTD and STD

Employer eligibility

- STD and LTD can be quoted for groups with:
  - 4-9 eligible employees
  - 10+ eligible employees
- Company must be in business a minimum of two years
- Group participation levels and employee eligibility must be verifiable through company records
- Not all industries are eligible for coverage – Please consult with your market Sales Representative to verify eligibility

7. Eligibility: Workplace Voluntary Benefits (WVB)

Companies must be in business a minimum of two years to be eligible to quote WVB. In addition, some industries are not eligible to quote, or require prior approval before producing a quote. Samples of these industries are:

- Adult Entertainment
- Contract Employees
- Professional Employees Organizations
- Unions

Please contact your Humana Sales Representative for any further questions.

8. Underwriting – WVB

Humana uses four levels of underwriting for Workplace Voluntary Benefits. All levels are designed for "accept or reject" decisions. The level of underwriting for a specific case will depend on the product(s) sold and case demographics.

Jet Issue

- A limited form of medical underwriting that applies to non-Critical Illness Cancer products only
- Only one medical question is required to be answered on the employee application
- Integrated application will require 2 AIDS and 1 Cancer question to be answered
- Requires a minimum participation level

Simplified Issue (SI) is an offer to medically evaluate risk as applied for without requiring a physical or home office specimen:

- Medical questions are required to be answered on the employee application
- Requires a minimum participation level per product line

Contingent Guarantee Issue (CGI) is a form of limited medical underwriting that requires:

- A limited number of medical questions to be answered on the employee application
- A specified participation level per product line
- Coverage to be applied for within the CGI plan design limits
- All questions to be completed

Guaranteed Issue (GI):

- Allows for all actively at work employees to participate in coverage, provided participation has been met
- Requires a specified participation level per product line
- Coverage is required to be applied for within the GI plan design limits
- All questions need to be completed

Takeovers

A takeover occurs when Humana is replacing another carrier's coverage product with a Humana product. Takeover reduces the Humana policy's pre-existing condition clause by the number of months equal to the number of months the prior policy was in force.

- **Example:** An employer has a disability benefit with another carrier for six (6) months prior to replacing with Humana Disability product, a pre-existing condition on the Humana policy would be six (6) months rather than twelve (12).

Products that are eligible for takeover are Disability Income Advantage, Critical Illness, Supplemental Health, and Disability Income Plus for groups with 51 or more eligible lives.

In order to enroll with a takeover provision:

- The account must be pre-approved by underwriting
- Applicants must be replacing similar coverage
- The prior coverage was in force within 60 days for Disability Income Advantage and 63 days for Disability Income Plus.

An approved takeover does not guarantee coverage for applicants. Applicants will be subject to normal risk evaluation when applying for coverage.

Note: If a group is provided a takeover benefit, the agent's commission will be reduced. Please refer to your Workplace Benefit Specialist

Portability

Coverage can be continued on a direct pay basis after policy holder terminates their employment if the product is eligible for portability based on the policy language.

Not all products INCLUDE portability. Please contact your Humana Sales Representative for details.

9. Eligibility: Employee

Eligibility requirements

Employee means a person who is:

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:

- On a regular basis
- For the required hours per week shown on the Employer Group Application

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 United States citizen. If the employee is not a US citizen, but they hold a green card or VISA and meets Humana's definition of an active full time employee, they are eligible for coverage

Independent contractor eligibility (1099 employees)

We will not accept a group of 100% independent contractors. We must have at least one employee on a wage and tax statement. Independent contractors are not eligible if not working exclusively for the employer group enrolling.

A full time employment questionnaire and their 1099 tax statements are required for all these independent contractors.

Waiting periods / probationary periods

At initial group enrollment, all full-time employees are eligible for coverage.

The maximum waiting period for medical groups will be 90 days, immediate. HMO plans must select a maximum of 60 days 1st of the month.

Employers of 2 or more enrolled lives may elect up to two waiting periods. If multiple waiting periods are elected by the employer they must be defined by class of employee and must be used for all lines of coverage.

Retiree

Early retirees (those <65) are not eligible for coverage.

Retiree coverage is an option available for companies of 26 or more active employees enrolling for coverage. Please note, in Texas retiree coverage is only available for groups of 51-99 enrolled.

- The minimum age for retiree eligibility is 65.
- The employer can select the number of years of service.

Number of retirees cannot exceed 10% of the group. If the number of retirees exceeds 10%, the retiree class is not eligible.

Retirees are eligible for medical, dental and vision coverage only.

10. Eligibility: Dependent

An eligible dependent is an employee's spouse or unmarried children. May include domestic partner, member of civil union, common law marriage or designated beneficiary, or legally recognized same sex spouse.

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.
- May include 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 child(ren)

With the enactment of federal health care reform, all medical insurance policies are required to increase the dependent maximum age to 26. Dependents, **married or unmarried** up to age 26 are eligible for medical, dental, life and vision.

A dependent is defined as a natural blood related child, step-child, 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. With the passage of federal healthcare reform:

- 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
Illinois	30	Yes, military veteran dependents
Nebraska	30	Yes
Ohio	27	Yes
Wisconsin	27	Yes, military veteran dependents

Call your local sales office for dependent eligibility guidelines for your state

11. 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 will be needed:

- Employer Group Application
- New Business quote
- Humana List Enrollment
- Health Status Questions may be required for life insurance
- HSA Employer Election form (if group has an HSA)

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

12. Multiple-choice product options

Medical

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

- 1-4 enrolled lives: one plan only
- 5-9 enrolled lives: two plans
- 10-99 enrolled lives: four plans

Groups in Texas can select up to four medical plans for case size 1+.

Dental

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

- 10-25 enrolled lives: two plans
- 26-99 enrolled lives: three plans

13. Multiple locations

All Community Rated groups will be rated under the home or main office location.

14. Participation requirements

Medical- Participation will not be validated

Dental

- **Employer Sponsored Dental:**
  - 50% participation after valid waivers
  - Groups unable to meet the 50% participation requirement will be required to enroll in a voluntary plan.

- **Voluntary Dental:** A minimum of 2 employees must enroll in dental coverage.

Life

- **Basic Life:**
  - Contributory requires 50%
  - Non-contributory requires 100% participation.
  - Contributory groups unable to meet the 50% participation requirement will be required to enroll in a voluntary plan.
  - Non-Contributory groups unable to meet the 100% participation requirement will be required to change their contribution amount
- **Voluntary Life:** A minimum of Five enrolled employees is required

LTD / STD

- **Contributory requires** 75% participation
- **Non-contributory requires** 100% participation

Vision

2+ Group Size written with Medical or Dental:

- Minimum of 25% participation
- A minimum of two enrolled employees is required
- Groups not able to meet these participation requirements will need to enroll in a voluntary plan.

2+ Group Size written stand alone:

- A minimum of five enrolled employees is required

WVB

The participation requirements for Humana Workplace Voluntary Products are illustrated:

Product	Minimum participation	Multiple Products
Supplemental health	2 employees	If two Workplace Voluntary Products are sold, will require two employees in each product.
All other WVB products	5 employees	If two Workplace Voluntary Products are sold, will require two employees in each product.

Please contact your Humana Sales Representative for any further questions

15. Renewals

Renewal notifications are sent to the agent and employer regarding the employer's upcoming renewal.

Renewals delivered

- Renewals are made available to agents generally seventy (75) days in advance of the renewal.
- All employers are sent a renewal letter generally sixty (60) days in advance of the renewal.

How to obtain renewal Information

Renewal information is available three ways:

- Employer Benefit Center (EBC)
- Renewal letters are e-mailed
- In the agent secured section of Humana.com

Online information has two options to obtain the renewal information:

- Employer Benefit Center (EBC)
- Benefit Utilization Director – BUD illustrates how employees utilize benefits. You can view how often employees:
    - Visit their doctors – participating & 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 client's.

The Benefit Utilization Director is located in the secured agent section of Humana.com.

Health Plan Guide

The Health Plan Guide is an informational packet that is sent directly to the employers twice a year. It is a summary of information that you can access through the Benefit Utilization Director (BUD). It provides the employer an overview of the benefit utilization of their plan benefits.

This packet is sent to the employer:

- Five months after the plan is effective.
- Four months before their renewal.

The Health Plan Guide is located in the secured agent section of Humana.com.

NON COMMUNITY-RATED MEDICAL

1. Case size

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

2. Contribution requirements

The employer is required to financially contribute toward the cost of the group insurance program to ensure the employer has 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.

Humana's standard contribution requirements are:

Line of coverage	Contribution requirements
Basic Life	Non-Contributory – 100% Contributory - 50%
Disability	Non-Contributory – 100% Contributory - 50%
WVB	0%
Medical	Contribution percentage will not be enforced
Dental	Contribution percentage will not be enforced
Employer-sponsored Vision	50%
Voluntary Plans	0%

3. Effective dates

- **Medical and Specialty:** Groups must have a 1st of the month effective date.
  NO EXCEPTIONS.
- **Life - Dependent Delayed Effective Date:**

  The dependent's effective date of coverage will be delayed if the dependent is:
  - Confined to a hospital or qualified treatment facility or
  - Receiving home health care or hospice benefits or
  - Not actively at work (applicable only to dependent spouse)

  The dependent's coverage will be effective on the day after:
  - Discharge from confinement (discharge must be certified by a qualified practitioner)
  - A qualified practitioner certifies that home health care 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 will not apply to the newborn child on the child's date of birth.

4. Eligibility: Medical, Dental, Vision, and Life

Employer eligibility

Groups that are eligible for non-community rated are employers that had a count of >50 in the preceding calendar year. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

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

- Employee eligibility must be verifiable through company records.
- Humana must be the exclusive health plan provider for employers with 1 - 99 employees on payroll.

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

Common control

Common control is the consolidation of control among two or more business. Businesses under a common control arrangement are governed by one individual (or group of individuals) in accordance with a contractual arrangement.

Groups under common control will have their counts combined.

The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

Employer with questions on common control should reach out to their tax advisors for advice. We will require the Humana Common Ownership form to be completed at enrollment.

Group qualifications: Guarantee access

An employer with a count of 51 or more that meets underwriting eligibility is guaranteed access to all available medical products. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

Determination of case size includes any individuals employed by an employer to include fulltime, part-time, temporary and seasonal employees, however, 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.

Carve outs – offering coverage to specific class of employees

These are the standard carve out guidelines.

Product line	Acceptable carve-out classes are limited to:
Medical 1-99 payroll or ancillary 2-99	• Salaried / hourly • Management / non-management • Union / non-union

Leasing company / employment agency / temporary agency

Leasing, employment and temporary agencies are eligible for coverage. Follow normal eligibility requirement including a prior carrier billing statement, when applicable.

Humana reserves the right to request additional eligibility information on a case-by-case basis.

PEO – Professional Employer Organization

PEO's 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 requires including a prior carrier billing statement, when applicable.

Humana reserves the right to request additional eligibility information on a case-by-case basis.

Start-up groups

A startup company is a company that hasn't been in business long enough to file a quarterly wage and tax statement. These groups must provide the following documents to Humana.

5. Eligibility: LTD and STD

Employer eligibility

- STD and LTD can be quoted for groups with:
  - 4-9 eligible employees
  - 10+ eligible employees
- Company must be in business a minimum of two years
- Group participation levels and employee eligibility must be verifiable through company records
- Not all industries are eligible for coverage – Please consult with your market Sales rep to verify eligibility

6. Eligibility: WVB

Companies must be in business a minimum of two years to be eligible for WVB coverage. In addition, certain groups require prior approval before quoting or are not eligible to purchase Workplace Voluntary Products. Samples of these groups are:

- Groups in the Adult Entertainment industry
- Groups with Contract Employees
- Professional Employees Organizations
- Unions

Please contact your Humana Sales Representative for any further questions.

7. Underwriting for WVB products

Humana uses four levels of underwriting for Workplace Voluntary Benefits. All levels are designed for "accept or reject" decisions. The level of underwriting for a specific case will depend on the product(s) sold and case demographics.

Jet Issue

- A limited form of medical underwriting that applies to non-Critical Illness Cancer products only
- Only one medical question is required to be answered on the employee application
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- Requires a minimum participation level

Simplified Issue (SI) is an offer to medically evaluate risk as applied for without requiring a physical or home office specimen:

- Medical questions are required to be answered on the employee application
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Contingent Guarantee Issue (CGI) is a form of limited medical underwriting that requires:

- A limited number of medical questions to be answered on the employee application
- A specified participation level per product line
- Coverage to be applied for within the CGI plan design limits
- All questions to be completed

Guaranteed Issue (GI):

- Allows for all actively at work employees to participate in coverage, provided participation has been met
- Requires a specified participation level per product line
- Coverage is required to be applied for within the GI plan design limits
- All questions need to be completed

Takeovers

A takeover occurs when Humana is replacing another carrier's coverage product with a Humana product. Takeover reduces the Humana policy's pre-existing condition clause by the number of months equal to the number of months the prior policy was in force.

- **Example:** An employer has a disability benefit with another carrier for six (6) months prior to replacing with Humana Disability product, a pre-existing condition on the Humana policy would be six (6) months rather than twelve (12).

Products that are eligible for takeover are Disability Income Advantage, Critical Illness, Supplemental Health, and Disability Income Plus for groups with 51 or more eligible lives.

In order to enroll with a takeover provision:

- The account must be pre-approved by underwriting
- Applicants must be replacing similar coverage
- The prior coverage was in force within 60 days for Disability Income Advantage and 63 days for Disability Income Plus.

An approved takeover does not guarantee coverage for applicants. Applicants will be subject to normal risk evaluation when applying for coverage.

Portability

Coverage can be continued on a direct pay basis after policy holder terminates their employment if the product is eligible for portability based on the policy language.

Not all products INCLUDE portability. Please contact your Humana Sales representative for details.

8. Eligibility: Employee

Eligibility requirements

Employee means a person who is:

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:

- On a regular basis
- For the required hours per week shown on the Employer Group Application

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 10% of the entire group
- An employee must be a United States citizen. If the employee is not a US citizen but they hold a green card or VISA and they meet the other definitions of an active full time employee, they are eligible for coverage

Independent contractor eligibility (1099 employees)

We will not accept a group of 100% independent contractors. We must have at least one employee on a wage and tax statement. Independent contractors are not eligible if not working exclusively for the employer group enrolling.

A full time employment questionnaire and their 1099 tax statements are required for all these independent contractors.

Waiting periods / probationary periods

At initial group enrollment, all full-time employees are eligible for coverage.

The maximum waiting period for medical groups will be 90 days, immediate. HMO plans must select a maximum of 60 days or less.

Employers of 2 or more enrolled lives may only elect up to two waiting periods. If multiple waiting periods are elected by the employer they must be defined by class of employee and must be used for all lines of coverage.

Retiree

Early retirees (those <65) are not eligible for coverage.

Retiree coverage is an option available for companies of 26 or more active employees enrolling for coverage. Please note, in Texas retiree coverage is only available for groups of 51-99 enrolled.

- The minimum age for retiree eligibility is 65.
- The employer can select the number of years of service.

Number of retirees cannot exceed 10% of the group. If the number of retirees exceeds 10%, the retiree class is not eligible.

Retirees are eligible for medical, dental and vision coverage only.

9. Eligibility: Dependent

An eligible dependent is an employee's spouse or unmarried children. May include domestic partner, member of civil union, common law marriage or designated beneficiary or legally recognized same sex spouse.

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.
- May include 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 child(ren)

With the enactment of federal health care reform, all medical insurance policies are required to increase the dependent maximum age to 26. Dependents, **married or unmarried** up to age 26 are eligible for medical, dental, life and vision.

A dependent is defined as a natural blood related child, step-child, 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. With the passage of federal healthcare reform:

- 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
Illinois	30	Yes, military veteran dependents
Nebraska	30	Yes
Ohio	27	Yes
Wisconsin	27	Yes, military veteran dependents

Call your local sales office for dependent eligibility guidelines for your state

10. 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 will be needed:

- Employer Group Application
- New Business quote
- Humana List Enrollment
- Health Status Questions may be required for life insurance and applicants not currently enrolled for medical coverage
- HSA Employer Election form (if group has an HSA)

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

11. Multiple-choice product options

Medical

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

- 1-4 enrolled lives: one plan only
- 5-9 enrolled lives: two plans
- 10-99 enrolled lives: four plans

Groups in Texas can select up to four medical plans for case size 1+.

Dental

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

- 10-25 enrolled lives: two plans
- 26-99 enrolled lives: three plans

12. Participation requirements

Medical

Due to ACA, Humana is not able to enforce participation requirements for groups in this case size at New Business time, but can be reviewed/enforced at renewal.

Dental

- **Employer Sponsored Dental:**
    - 50% participation after valid waivers
    - Groups unable to meet the 50% participation requirement will be required to enroll in a voluntary plan.

- **Voluntary Dental:** A minimum of 2 employees must enroll in voluntary dental coverage.

Life

- **Basic Life:**
    - Contributory requires 50% participation
    - Non-contributory requires 100% participation
    - Contributory groups unable to meet the 50% participation requirement will be required to enroll in a voluntary plan.
    - Non-Contributory groups unable to meet the 100% participation requirement will be required to change their contribution amount.

- **Voluntary Life:** A minimum of Five enrolled employees is required

LTD / STD

- **Contributory requires** 75% participation
- **Non-contributory requires** 100% participation

Vision

2+ Group Size written with Medical or Dental:

- Minimum of 25% participation
- A minimum of two enrolled employees is required
- Groups not able to meet these participation requirements will need to enroll in a voluntary plan.

2+ Group Size written stand alone:

- A minimum of five enrolled employees is required

WVB

The participation requirements for Humana Workplace Voluntary Products are illustrated:

Product	Minimum participation	Multiple Products
Supplemental health	2 employees	If two Workplace Voluntary Products are sold, will require two employees in each product.
All other WVB products	5 employees	If two Workplace Voluntary Products are sold, will require two employees in each product.

Please contact your Humana Sales Representative for any further questions

13. Renewals

Renewal notifications packets are sent to the agent and employer regarding the employer's upcoming renewal. The packets contain a variety of information as it relates to the group, product, and rating for the future year. Other information may be included if it may impact the group's renewal.

Renewals delivered

- Renewals are made available to agents generally seventy (75) days in advance of the renewal.
- All employers are sent a renewal letter generally sixty (60) days in advance of the renewal.

How to obtain renewal Information

Renewal information is available three ways:

- Employer Benefit Center (EBC)
- Renewal letters are e-mailed
- In the agent secured section of Humana.com

Online information has two options to obtain the renewal information:

- Employer Benefit Center (EBC)

- Benefit Utilization Director – BUD illustrates how employees utilize benefits. You can view how often employees:
    - Visit their doctors – participating & 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 client's.

The Benefit Utilization Director is located in the secured agent section of Humana.com.

Health Plan Guide

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

This packet is sent to the employer:

- Five months after the plan is effective.
- Four months before their renewal.

The Health Plan Guide is located in the secured agent section of Humana.com.

Quoting

COMMUNITY-RATED MEDICAL

1. Quote requests

You can create a quote from your computer when you need it at Humana.com, under the secured agent section, for companies with counts of 1 - 50 employees for medical coverage (additionally, dental, vision, life, and Workplace Voluntary Benefit coverage quotes are available). All community rated groups will be quoted as single site. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

Agents are able to quote medical, dental, vision, life and short term and long-term disability for case sizes 2+.

Other methods to get a quote

- Call Easy Rate at 1–800–327–9728
- Fax to 1–800–344–3294
- E-mail easyrate@humana.com – for groups that are not currently with Humana
- E-mail conservation@humana.com – for existing groups already with Humana

Information you'll need to quote companies with 1-50 employees. The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

- Broker/Agent Tax ID SSN 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)
- Number of COBRA employees, if applicable
- Number of Retiree employees, if applicable
- Requested effective date
- Fax number or e-mail address for quote delivery
- 24-hour coverage available for owners, officers and partners.
  (Not applicable in Texas, Florida, Kansas & Kentucky)

Member information

- Gender
- Age or birth date
- Coverage type (single, family, employee with child(ren), employee with spouse, and waivers)
- Medicare Eligibility

Dependent information – Required at quote time

- Spouse - Age/Date of Birth and Gender, Medicare Eligibility
- Dependents - Age/Date of Birth, Gender, and Dependent Status
- Medical information (if Underwritten Quote for groups with payroll count of >50)
- Requested plan(s): Provide specific names of products you want quoted
- Salary data if requesting a salary plan for Life products or any STD/LTD products
- Agent tax identification, Social Security number, or your Humana Agent number, which can be found on your commission check.
- Fax number or e-mail address for quote delivery
- 24-hour coverage available for owners, officers and partners.
  (Not applicable in Texas, Florida & Kentucky)

NON COMMUNITY-RATED MEDICAL

1. Quote requests

For companies with counts of >50 or multi-location companies, please contact your local sales office or Easy Rate for medical coverage quotes (additionally, dental, vision, life, and short term disability, long term disability and Workplace Voluntary Benefit coverage quotes are available).

The count may be based on payroll, full time equivalent or eligible as determined by state legislation

You can create a single-location quote from your computer when you need it at Humana.com, under the secured agent section, dental, vision, life, and Workplace Voluntary Benefit coverage quotes are available.

Agents are able to quote medical, dental, vision, life and short term and long term disability for case sizes 2+.

Methods to get a quote

- Call Easy Rate at 1–800–327–9728
- Fax to 1–800–344–3294
- E-mail easyrate@humana.com – for groups that are not currently with Humana
- E-mail conservation@humana.com – for existing groups already with Humana

Information you'll need to quote companies with 1-99 employees on payroll

- Broker/Agent Tax ID SSN or Humana Assigned Number

- Name, address and phone number of employer
- Payroll count/ATNE or full time equivalent
- Eligible Count
- Nature of business and standard industry code (SIC)
- Number of COBRA employees, if applicable
- Number of Retiree employees, if applicable
- Requested plan(s): Provide specific names of products you want quoted
- Requested effective date
- Fax number or e-mail address for quote delivery
- 24-hour coverage available for owners, officers and partners.
  (Not applicable in Texas, Florida, Kansas & Kentucky)

Member information

- Gender
- Age or birth date
- Disability Status
- Medicare Eligibility
- Coverage type (single, family, employee with child(ren), employee with spouse, and waivers)
- Medical information (if Underwritten Quote for groups with payroll count of >50)
- Salary data if requesting a salary plan for Life products or any STD/LTD products

Dependent information – Not required at quote time

- Spouse - Age/Date of Birth and Gender, Disability Status, Medicare eligibility – Not required at quote time
- Dependent - Age/Date of Birth, Gender, and Dependent Disability Status – Not required at quote time
- Medical information (if Underwritten Quote for groups with payroll count of >50)

2. Multiple locations

Multiple Business Locations

For companies with counts of >50: The count may be based on payroll, full time equivalent or eligible as determined by state legislation.

- If quoting a company with more than one business location, provide the above information by location.
- A separate billing fee for each location may apply

Excluding a location

Companies of 2 - 99 eligible employees must have filed a separate federal income tax return for each entity or business location they wish to exclude from coverage

Enrollment requirements

Humana requires the following information for enrollment. Please send materials to your sales representative or sbsales@humana.com no later than the 15th of the month before the requested effective date.

- Most recent version of the Employer Group 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)
- 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. The list enrollment is available for all Specialty Groups (except SD) and Non-Community Rated groups upon Underwriting approval only. See the chart below for List Enrollment availability:

State	**1-50** (medical with dental, life*, vision, disability)	**51+** (medical with dental, life*, vision, disability)	**2-99 specialty only** (dental, life*, vision, disability)	**WVB** (FYI: as these lines are enrolled in LV)
CO	Universal app must be used for medical. Specialty can be enrolled on List Enrollment	Upon underwriting approval	Yes	GI products only
UT	Universal app must be used for medical. Specialty can be enrolled on List Enrollment	Upon underwriting approval	Yes	GI products only
SD	N/A – medical exit state	N/A – medical exit state	No	No
All other	List Enrollment can be used to enroll all lines	Upon underwriting approval	Yes	GI products only

- An application or waiver form must be requested for any individual within his/her continuation/COBRA election period
- Waiver forms must be completed and submitted for employees not electing coverage for themselves or their eligible dependents. 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 will be returned for updating.
    - All cases – The final quote version must be free of assumptions
    - Non-Community Rated medical - A fully risk-rated/Underwritten quote is required
- Copy of current carrier's most recent billing statement
    - Non-Community Rated medical
    - 2-9 enrolling Dental
    - 10+ enrolling Voluntary Dental w/Ortho coverage
    - LTD/STD
- Certificate of Coverage – LTD & STD
- Signed and dated Rating and Renewability Disclosure (for Wisconsin only). The Wisconsin Rating and Renewability form must be signed before signing the Employer Group Application and must be received with the new case submission.
- Eligibility Certification Form for contracted or commissioned (1099) enrollees who meet the definition of an eligible employee.
- Full-time Employment Questionnaire for contracted or commissioned (1099) enrollees who meet the definition of an eligible employee.
- 1099 or 1096 Form for contracted or commissioned (1099) enrollees
- Multi-location form, if the sold group is a multi-location (applies to groups with counts of 51+).
- Humana Health Saving Account Employer Election form, if applicable
- Humana Personal Care Account Employer Election form, if applicable (Health Reimbursement Account)
- NPOS Disclosure Form, for all NPOS groups sold in Texas
- Signed and dated Attestation form, if applicable

Cases may be returned during the review process if:

- Incorrect applications submitted
- List enrollment utilized when not allowed
- Group determined to be Non-Community Rated and the submitted case is Community Rated (non-underwritten quote, incorrect product, no medical information provided)

Cases requesting missing information must have the information returned within five (5) business days. Cases that do not return the requested information in the allotted time will be 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

ALL PRODUCTS EXCEPT WORKPLACE VOLUNTARY BENEFITS

1. Premium billing

Paper invoices are generated around the 15th day of the month and electronic invoices are generated on the 25th day of the month preceding the month of coverage. Premium payments are due on the first day of the applicable coverage month. For example, Humana produces the invoice for the month of May in April and the premium is due on or before May 1st.

If premium due is not received by the 15th of the month, the group will receive a reminder letter informing them premium has not been received. If premium due is not received by the 31 days after the due date, the group will be terminated and receive 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.

2. eBilling

We encourage you to inform the group's Benefit Administrator to use our online billing tool to make payments and submit terminations. The benefits of using our online billing center include:

- View a PDF of an invoice
- Instant receipt of termination credits
- Download billing details into a report format
- Online payment options – one-time payment or recurring
- Set email billing notifications
- View recent activity on the account

eBilling is in the secure employers' section of Humana.com. Through Agent Delegation, these tools can be accessed in the secured agent section of Humana.com.

3. Automatic withdrawal – ACH form

Using Humana's Automated Clearing House form allows the group to set up a recurring payment schedule for automatic bank withdrawals from their bank account. The form can be found at Humana.com in the Forms for Agent and Brokers or the group can set up a recurring payment in eBilling.

1. Premium billing

Paper invoices are generated around the 15th day of the month and electronic invoices are generated on the 25th day of the month preceding the month of the coverage. Premium payments are due the first of the month after the applicable coverage month. (Example: January invoice will be due February 1st). Available invoice Frequencies are: monthly, 9thly (9 invoices a year), 10thly (10 invoices a year) and 13thly (every 4 weeks). Policy level deductions will be set up according to payroll deduction frequency, which include weekly, biweekly, semi-monthly and monthly.

2. Payment

- The group will need to remit detailed back up along with payment that includes the following: member's name, SSN/policy number, amount paid, product, and period paid for.
- Payment address
  Kanawha Insurance Company
  PO Box 371494
  Pittsburgh, PA 15250-7494

3. eBilling

We encourage you to inform the group's Benefit Administrator to use our online billing tool to make payments. The benefits of using our online billing center include:

- View a PDF of an invoice
- Download billing details into a report format
- Online payment options – one-time payment or recurring
- Set email billing notifications
- View recent activity on the account

eBilling is in the secure employers' section of Humana.com. Through Agent Delegation, these tools can be accessed in the secured agent section of Humana.com.

4. Automatic withdrawal – ACH form

Using Humana's Automated Clearing House form allows the group to set up a recurring payment schedule for automatic bank withdrawals from their bank account. The form can be found at Humana.com in the Forms for Agent and Brokers or the group can set up a recurring payment in eBilling.

5. Discrepancies

- Once premium is received, the billing representative will report any discrepancies back to the group via email
- Discrepancies will include the following:
  1. Billed not paid – any policy that we billed for that was not paid for
  2. Paid not billed – any policy that the group paid for that we did not bill for
  3. Rate discrepancies – any difference in billed vs. paid

- If a member policy falls 90 days behind in payment, the policy will lapse, and may be terminated, due to non-payment

6. Collection process

- Premium payments are due the first of the month after the applicable coverage month. (Example: January invoice will be due February 1st)
- A warning letter will generate 15 days after due date
- A termination letter will be sent for non-payment if premium is not received by the 31st day after the due date

7. Terms

Termination requests can be remitted on the payment roster or can be sent directly to the billing department via email at GBSmallGroupBilling@Humana.com.

8. Employee cancellation requests

Employees requesting to cancel their policy can fax the request to 1-866-584-9140 or send it to the following address:

Humana Enrollment
PO Box 14330
Lexington, KY 40512-4330

Group maintenance

NEW HIRES, CHANGES, AND TERMINATIONS

1. Enrolling a new employee

A new employee can apply based on the eligibility requirements illustrated on the Employer Group Application. An enrollment form must be completed, dated and signed before it can be processed. You may access Humana.com for the most current forms and enrollment options.

New employees can be enrolled in the following ways:

- Fax the enrollment form to Enrollment at 1-866-584-9140.
- Mail the enrollment form to Enrollment at:

  Humana Enrollment
  PO Box 14209
  Lexington, KY 40512-4209
- Overnight enrollment form to Enrollment at:

  Humana Enrollment
  2432 Fortune Drive
  Suite 120
  Lexington, KY 40509-4269
- Enter the request on our easy to use online administrative tool on Humana.com. Through Agent Delegation, these tools can be accessed in the secured agent section of Humana.com.

The most current forms are located on the agent section of Humana.com. Select Printable Enrollment and Change Forms link under Customer Support for Agents. If you prefer, you can order them via the agent secured section of Humana.com under Market & Products and selecting the Order Marketing Material link.

Using the most current enrollment forms helps ensure the enrollment will be processed more quickly and avoid unnecessary delays.

Note: An employee who wants basic or voluntary life insurance for more than the guaranteed issue amount needs to complete an Evidence of Insurability form. Underwriting may request additional information upon application review.

2. Timely applicant

A timely applicant is any employee or dependent applying for coverage within 31 days of the eligibility date or within 31 days of a qualifying event. The eligibility date is defined as 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 (not applicable to Disability; STD/LTD)
- Divorce (not applicable to Disability; STD/LTD)

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

3. Late applicant

Any employee or dependent applying for coverage outside the open enrollment period 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 open enrollment period, a courtesy letter will be mailed to both the employer and member to notify them that the application will not be processed and to advise the member during the next open enrollment dates.

4. Open enrollment

Open enrollment typically occurs on an annual basis thirty-one (31) days before and after the group policy renewal date. During this time, eligible employees and eligible dependents can enroll for coverage under the group policy. Any individuals who were deemed late applicants may enroll at the group's next open enrollment period. Unless there is a qualifying event, eligible employees must wait until the next open enrollment period to enroll for the group coverage.

Specialty Benefit products, with an open enrollment period, have the ability to change the open enrollment period, 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, product offering. Certain products, for example our DHMO product, include the open enrollment provision.

5. Employee coverage change

Employers can make employee coverage changes by submitting an Employee Change Form or agents can by making the change via 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 the other 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)

**Note: For LTD/STD, any request for coverage over the guarantee issue amount may require an Evidence of Insurability form and will be subject to underwriting approval.*

A Change Request can be submitted by:

- Fax the enrollment form to Billing and Enrollment at 1-866-584-9140.
- Mail the enrollment form to Billing and Enrollment at:

  Humana Enrollment
  PO Box 14209
  Lexington, KY 40512-4209

- Enter the request on our easy to use online administrative tool on Humana.com. To access this information, you or your office would have to utilize Agent Delegation, which is located in the secured agent section of Humana.com.

6. 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 employer group application.

To ensure only eligible members receive benefits under the policy, 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 on Humana.com. To access this information, you or your office would have to utilize Agent Delegation, which is located in the secured agent section of Humana.com.
- Call the Agent Center of Excellence at 1-800-592-3005 and complete the member termination by following 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 will not backdate a termination more than 60 days from the time the termination request is received, unless required by state law.
- Certificate of Prior Coverage:
    - Humana will provide terminated individuals notification for all medical policies.
    - Humana will provide terminated individuals notification for applicable specialty benefit policies upon request.

PLAN CHANGE: GROUPS SIZE 2-99

1. Medical

Adding a medical plan

A plan-add is defined as adding an additional line of coverage to an existing group. Adding additional products to an already existing line of coverage is considered a plan change.

When adding a medical plan to an existing group (one in which there is not a current Humana medical product), please submit the documentation listed below.

- Must be submitted 10 business days prior to the effective date.
- General turnaround time for a plan-add is 5 to 7 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting required documentation for a plan-add:

- Email to beclericals@humana.com
- Fax to 1-877-369-5615

Plan-add documentation and rules guide

Coverage added*	Documentation requirements / rules**
Adding medical coverage	• Employer Group Application • Enrollment forms or Humana List Enrollment • Waivers (required for Community Rated Medical plans in the following states – OK, CO, TX, UT, and WI • Final quote • Copy of current billing statement if group had a prior carrier • Gatekeeper questions, Evidence of Health Status, or Risk Assessment Form (varies by group size and state) • Attestation Form (if applicable)
Adding a HSA (High Deducible Health Plan is required)	• Employer Group Application • Enrollment forms • Humana Health Savings Account Employer Election Form

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-92-3005 for additional information and/or questions.*

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

Changing a medical plan

A plan change is defined as making a benefit modification to an existing product or adding an additional option to an existing line of coverage.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 70 business days prior to the effective date.
- General turnaround time for plan changes is 3-5 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting required documentation for a plan-change:

- Employer Benefit Center on Humana.com (EBC)
- Email to beclericals@humana.com

Plan change documentation and rules guide

Change in coverage*	Documentation requirements / rules**
Changing from one single option product to another single option product **on renewal**	• Group Plan Change Request form • Final quote • Attestation Form (if applicable)
Changing from one single option product to another single option product **off renewal**	• Group Plan Change Request form • Final quote • Attestation Form (if applicable) • Subject to Underwriting approval • Movement from non-HDHP product to HDHP or EHDHP product is prohibited • Movement from non-CoverageFirst product to CoverageFirst is prohibited
Changing from a single or multiple option to multiple options **on renewal**	• Group Plan Change Request form • Final quote • Enrollment forms or a list enrollment spreadsheet for members with product selection • Attestation Form (if applicable)
Changing from a single or multiple options to multiple options **off renewal**	• Group Plan Change Request form • Final quote • Enrollment forms or a list enrollment spreadsheet for members with product selection • Attestation form (if applicable) • Subject to Underwriting approval • Movement from non-HDHP product to HDHP or EHDHP product is prohibited • Movement from non-CoverageFirst product to CoverageFirst is prohibited
Employer Benefit Center	

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

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

2. Dental & Vision

Adding a dental or vision plan

A plan-add is defined as adding an additional line of coverage to an existing group. Adding additional products to an already existing line of coverage is considered a plan change.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 10 business days prior to the effective date.
- General turnaround time for plan changes is 5 to 7 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting required documentation for a plan-add:

- Email to beclericals@humana.com
- Fax to 877-369-5615

Plan-add documentation and rules guide

Coverage added*	Documentation requirements / rules
Adding dental or vision coverage	• Employer Group Application • List Enrollment or Enrollment forms and waivers • Final quote • Prior carrier information (applicable to dental only)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

Changing a dental or vision plan

A plan change is defined as making a benefit modification to an existing product or adding an additional option to an existing line of coverage.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 10 business days prior to the effective date.
- General turnaround time for plan changes is 3-5 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting required documentation for a plan-change:

- Employer Benefit Center on Humana.com (EBC)
- Email to beclericals@humana.com

Plan Change Documentation and Rules Guide

Change in coverage*	Documentation requirements / rules
Changing from one single option product to another single option product **on renewal**	• Group Plan Change Request form • Final quote
Changing from one single option product to another single option product **off renewal**	• Group Plan Change Request form • Final quote
Changing from a single or multiple option to multiple options	• Group Plan Change Request form • Final quote • Enrollment forms or a list enrollment spreadsheet for members with product selection
Employer Benefit Center	

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

3. Life

Adding a life plan

A plan-add is defined as adding an additional line of coverage to an existing group. Adding additional products to an already existing line of coverage is considered a plan change.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 10 business days prior to the effective date.
- General turnaround time for plan-adds is 5 to7 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

If amount requested is guaranteed issue amount (GIA) or below, there are two options for submitting a plan-add required documentation (Please note, any life amounts over the guarantee issue amount need to be routed through your Humana Sales Associate):

- Email to beclericals@humana.com
- Fax to 877-369-5615

Plan-add documentation and rules guide

Coverage added*	Documentation requirements / rules
Adding life coverage	• Employer Group Application • List Enrollment or Enrollment forms and waivers • Final quote • Evidence of Health Status if over the guarantee issue amount

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

Changing a life plan

A plan change is defined as making a benefit modification to an existing product or adding an additional option to an existing line of coverage.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 10 business days prior to the effective date.
- General turnaround time for plan changes is 3 to 5 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting a plan-change required documentation (Please note – if Life amount requested is over the Guarantee Issue, please consult your Humana Sales Associate):

- Email to beclericals@humana.com
- Fax to 1-877-369-5615

Plan change documentation and rules guide

Change in coverage*	Documentation requirements / rules
Changing from one single option product to another single option product **on renewal**	• Group Plan Change Request form • Final quote
Changing from one single option product to another single option product **off renewal**	• Group Plan Change Request form if reduction in premium and not within 90 days of group's renewal • Final quote
Changing life volume from single / flat amount to a class schedule	• Group Plan Change Request form • Final quote • List of member, their class, and amounts
Changing life amounts	• Group Plan Change Request form • Final quote • Evidence of Health Status (if amount requested is over Guarantee Issue)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

4. Short Term Disability (STD) and Long Term Disability (LTD)

Adding a STD or LTD plan

A plan-add is defined as adding an additional line of coverage to an existing group. Adding additional products to an already existing line of coverage is considered a plan change.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 75 business days prior to the effective date.
- General turnaround time for a Plan Add is 10 to 14 business days from receipt. Inventory fluctuations or missing required documentation can impact turnaround

There are two options for submitting a plan-add required documentation:

- Email to beclericals@humana.com
- Fax to 877-369-5615

Plan-add documentation and rules guide

Coverage added*	Documentation requirements / rules
Adding STD or LTD coverage	• Master Application (STD / LTD) • List Enrollment census or Group Disability Insurance Enrollment forms (form 1493) • Evidence of Insurability (EOI) only for benefits over guarantee issue (form 1490) • Sold quote • Prior carrier billing, if applicable • Prior carrier policy / certificate, if applicable (Note: the claims vendor request this information if not received) • Reinsurance rates / admin expense allowance (display screen shot provided by Underwriting) • Quoting Census spreadsheet (provided by Underwriting when paper enrollment forms are received)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

Changing a STD or LTD plan

A plan change is defined as making a benefit modification to an existing product or adding an additional option to an existing line of coverage.

- On renewal, must be submitted 10 business days prior to the effective date.
- Off renewal, must be submitted 70 business days prior to the effective date.
- General turnaround time for a Plan Change is 10 to 14 business days from receipt. Inventory fluctuations or missing required documentation could impact turnaround.

There are two options for submitting required documentation for a plan-change:

- Email to beclericals@humana.com
- Fax to 1-877-369-5615

Plan change documentation and rules guide

Change in coverage*	Documentation requirements / rules
Changing from one single option product to another single option product **on renewal**	• Group Plan Change Request form • Final quote
Changing from one single option product to another single option product **off renewal**	• Group Plan Change Request form • Final quote

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

GROUP OR LINE OF BUSINESS TERMINATION

Groups may terminate coverage at any time if written notice is received before the requested termination date. All premium payments will be 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 will 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.

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) • E-mail through the secure Employer Portal on Humana.com • Plan Change Request Form (signed by a group contact or owner / officer)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

The following table illustrates the state specific termination rules:

State	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

ADDING A LOCATION OR BILLING DIVISION

Multiple Business Locations

For companies of 51-99 eligible employees enrolling for coverage:

- If quoting a company with more than one business location, provide the above information by location.
- A separate billing fee for each location may apply

Change requested*	Documentation requirements / rules
Adding a location or billing division (billing division can only be done upon renewal)	• Multi-location form • Final quote • Employer Group Application (if issue state is changed or added) • Enrollment forms for new employees • Attestation Form (if applicable)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

EMPLOYER ADDRESS CHANGE

Requests must come from:

- Administrative or management contact
- Agent of record
- Market office

Change requested*	Documentation requirements / rules
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	• Email from group contact • Call into contact center • Letter on company letterhead • Letter on company fax sheet • Web request • Group Plan Change Request form • Employer Group Application (EGA)
Employer address change (moved to a new state)	• Employer Group Application (EGA) based on new issue state of company • Enrollment forms, only if the company is electing a provider required plan (HMO, POS, etc.) • Alternate quote
Employer address change (moved to a new market)	• Plan Change Request form • Employer Group Application (EGA) • Enrollment forms, only if the company is electing a provider required plan (HMO, POS, etc.) • Alternate quote

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

COMPANY CONTACT CHANGE

A group contact addition or change request must be signed by a group/company contact, owner (includes an officer or the president), or a new company contact (if previous contact is no longer with the group).

Change requested*	Documentation requirements / rules
Company contact change	• Email from group contact • Letter on company letterhead • Letter on company fax sheet • Web request • Group Plan Change Request form • Employer Group Application (EGA)

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

COMPANY NAME CHANGE

A group or division name change request must be signed by a group contact or owner (to include officer or president) on an EGA.

Change requested*	Documentation requirements / rules
Company name change	• Email from group contact • Employer Group Application (EGA) • Plan Change Request form • Letter on Company letterhead • Letter on Company fax sheet

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

PROBATIONARY WAITING PERIODS

Medical:

The chart below illustrates what a group may select as benefit probationary waiting period. Effective date provisions are either 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 Employer Group Application and does not assume that one-month is 30 days.

As a provision of Health Care Reform, the Affordable Care Act (ACA) provides that, for plan years beginning on or after January 1, 2014, a group health plan or insurers offering group health coverage may not apply an eligibility probationary period, also called a waiting period (the length of time employees must be actively at work before becoming eligible for the group's medical insurance) that exceeds 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 charts:

Product	**Effective date provisions**
Traditional HMO in Chicago, Nevada, Florida, and Kansas City	First of the month following the completion of the probationary waiting period
Traditional POS in Chicago, Nevada, Florida, and Kansas City	First of the month following the completion of the probationary waiting period
All other 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 HMO's) with select network configuration, will only be allowed to have First of the Month following. Please check with your Humana Sales Associate for further clarification.

Change requested*	**Documentation requirements / rules**
Waiting period	• Employer Group Application (EGA) • Plan Change Request Form • Letter

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

Dental, Vision, Life, Short-term Disability, Long-term Disability:

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 charts:

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

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

The table below lists state specific exceptions to the above stated probationary waiting period rules:

State	Probationary waiting period rule
Florida	Florida law does not allow multiple probationary waiting periods for different classes of employees for 2-50 group size
Kansas	The maximum probationary waiting period is immediately following 90 days or first of the month following 90 days
Maryland	The probationary waiting period cannot exceed 90 days
New Jersey	The maximum probationary waiting period cannot exceed 180 days, but the group could choose 150 and 1st of the month following
North Carolina, North Dakota, and Ohio	The maximum probationary waiting period is immediately following 90 days
Texas	• For group size 2-50, the maximum probationary waiting period is first of the month following 90 days when electing medical • Groups electing specialty benefit products only can have up to 365 days maximum probationary waiting period • 2-50 size groups in Texas cannot choose more than one probationary waiting period • When offering more than one product option on a group, the probationary waiting periods and effective date provisions must be same on all plans

Wisconsin	For groups 2-50, the maximum probationary waiting period is: • 1st of the month following five (5) months, or • Immediately following six (6) months
All other states	Follow general Humana probationary waiting period guidelines, illustrated above.

OPEN ENROLLMENT

Open enrollment typically occurs on an annual basis within a 31-day period of time around the group policy renewal date. During this time, eligible employees and eligible dependents can enroll for coverage under the group policy. Any individuals who were deemed late applicants may enroll at the group's next open enrollment period. Unless there is a qualifying event, late applicants must wait until the next open enrollment period to enroll for the group coverage.

1. Dental

Dental products with open enrollment have the ability to change the open enrollment period, 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

2. Vision

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

Change requested*	**Documentation requirements / rules**
Open enrollment period	• Plan Change form • Quote

* *The chart is not all-inclusive. Please contact Agent Center of Excellence at 800-592-3005 for additional information and/or questions.*

PORTABILITY

If an employee is eligible for portability, he or she must apply for coverage within 31 days of termination.

Portability

Life

An active eligible employee who leaves the group can continue voluntary life insurance by paying premiums to Humana if he or she is 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.

Portability is state-specific and is not available in Massachusetts and Minnesota. In addition, portability is available only with voluntary life in some states. Portability does not include AD&D, waiver of premium, and accelerated death benefit.

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 your company's payroll, which is subject to employment taxes. It is reduced by the amount employees contribute to certain employer-sponsored group benefit plans‑lowering some of your company's payroll-related taxes!

Additionally, your employees will have reduced their taxable income by making contributions they will pay less federal income, FICA (Social Security and Medicare tax), and most state income taxes– increasing your employees' take-home pay!

POP is administered through WageWorks. The fees associated with the administration of POP are illustrated below:

Segment	Fee: New business	Fee: Annual*
Medical	$0	$100
Dental (25 or more lives)	$0	$100
Dental (24 or less lives)	$125	$100
Vision	$125	$100
Term Life	$125	$100
Disability	$125	$100
Workplace Voluntary Benefits	$0	$0

* *If a Humana Workplace Voluntary product is added to the group, the annual fee will be waived.*

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 meets the 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.

A qualified benefit is a benefit that does not defer compensation and is 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

1. State continuation

Some states mandate continuation of benefit options for employees after they are no longer eligible for group coverage (employers with 19 or fewer employees). The employee's eligibility for state continuation is determined by the state where the company is located. Obtain specific guidelines and requirements for a state continuation by:

- Humana.com – Employer section, Customer Support for Employers, selecting Enrollment Guide
- Call Humana *Agent Center of Excellence at 800-592-3005*

2. 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 *Agent Center of Excellence at 800-592-3005*

COBRA administration is provided by Ceridian and is included as a value added benefit for Humana's fully insured medical coverage accounts. With Ceridian managing risk and compliance, Humana client's resource staff will be relieved of complex and time-consuming tasks. Information regarding Ceridian can be found at www.Ceridian-benefits.com. Ceridian can be contacted at:

- Humana Designated 800 number: 866-250-9474
- Email address: enhancedservices@Ceridian.com

3. Certificate of Group Health Plan Coverage (COBRA & State Continuation)

- Humana will provide terminated individuals notification for all medical policies.
- Humana will provide terminated individuals notification for applicable specialty benefit policies upon request.

4. Portability

Note: Portability applies to Life products only. See WVB section for portability rules on Voluntary Benefits.

An active eligible employee who leaves the group can continue voluntary life insurance by paying premiums to Humana if he or she is 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.

Portability is state-specific and is not available in Massachusetts and Minnesota. In addition, portability is available only with voluntary life in some states. Portability does not include AD&D, waiver of premium, and accelerated death benefit.