Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Group Vision Certificate of Insurance
Humana Insurance Company

Policyholder: TIGER WATERFRONT PRODUCTS

Policy Number: 836183

Effective Date: 01-01-2020

Product Name: MO HUMANA VISION 160,POLYCARB,12MO FRAME

In accordance with the terms of the *policy* issued to the *policyholder*, Humana Insurance Company certifies that a *covered person* is insured for the benefits described in this *certificate.* This *certificate* becomes the Certificate of Insurance and replaces any and all certificates and certificate riders previously issued.

Bruce Broussard
President

The insurance *policy* under which this *certificate* is issued is <u>not</u> a policy of Workers' Compensation insurance. *You* should consult *your employer* to determine whether *your employer* is a subscriber to the Workers' Compensation system.

This is <u>not</u> a policy of Long Term Care insurance.

>> This Benefit Plan Document is a summary of *your* Humana coverage

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Claims

How your plan works

As *you* read through this *certificate, you* will notice that certain words and phrases are printed in italics. An italicized word may have a different meaning in the context of this *certificate* than it does in general usage. Please check the "Definitions" section for the definitions of italicized words, so *you* can understand their meaning as it relates to *your* insurance coverage.

How to use this certificate

This *certificate* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It also identifies *your* duties and how much *you* must pay when obtaining services. Although *your* coverage is broad in scope, it is important to remember that *your* coverage has limitations. Be sure to read *your* certificate carefully before using *your* benefits.

Please note the provisions and conditions of this *certificate* apply to *you* and to each of *your* covered *dependents.*

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein, and the application of the *employees*, if any. All statements made by the *policyholder* or by an *employee* are considered to be representations, not warranties. This means that the statements are made in good faith.No statement made by any person insured shall be used in any contest.

General benefit payments

We pay *benefits* for *covered expenses,* as stated in the Schedule of Benefits and *your* "Vision Benefits" sections, and according to any riders that are part of *your policy*. Paid *benefits* are subject to the conditions, limitations and exclusions of this *policy*.

After *you* receive a *service, we* will determine if it qualifies as a *covered service*. If *we* determine it is a *covered service, we* will pay *benefits* as follows:

1. *We* will determine the total *covered expense.*
2. *We* will review the *covered expense* against any *reimbursement limit* that may apply.

Benefit maximums

The amount *we* pay for *services* are limited to a *reimbursement limit. We* will not make *benefit* payments that are more than the *reimbursement limit* for the *covered services* shown in the Schedule of Benefits.

How to find a preferred provider

An online directory of network providers will be made available to *you* and accessible via the internet on our website at **Humana.com** at the time of *your* enrollment. This directory is subject to change. Due to the possibility of *preferred providers* changing status, please check the online directory of *preferred providers* prior to obtaining services. If *you* do not have access to the online directory, *you* may telephone *our* customer service center prior to service being rendered or to request a directory.

Our relationship with providers

Preferred providers and *non-preferred providers* are not *our* agents, employees or partners. *Preferred providers* are independent contractors. *We* do not endorse or control the clinical judgment or treatment recommendation made by *preferred providers* or *non-preferred providers.*

Claims

Nothing contained in the *policy* or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between *you* and *vision providers* regarding *your* condition or treatment options. When ordering services, *vision providers* and other providers are acting on *your* behalf. All decisions related to patient care are the responsibility of the patient and the treating *vision provider*, regardless of any coverage determination(s) *we* have made or will make. *We* are not responsible for any misstatements made by any provider with regard to the scope of *covered expenses* and/or *non-covered expenses* under your *certificate*. If *you* have any questions concerning *your* coverage, please call the customer service number on the back of your identification card.

Privacy and confidentiality statement

We understand the importance of keeping *your* personal and health information (PHI) private. PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or Social Security number. *We* are required by applicable federal and state law to maintain the privacy of *your* PHI.

Under both law and our policies, *we* have a responsibility to protect the privacy of your PHI. *We*:

1. Protect *your* privacy by limiting who may see *your* PHI;
2. Limit how *we* may use or disclose *your* PHI;
3. Inform *you* of your legal duties with respect to *your* PHI;
4. Explain *our* privacy policies; and
5. Strictly adhere to the policies currently in effect.

We reserve the right to change *our* privacy practices at any time, as allowed by applicable law, rules and regulations. *We* reserve the right to make changes in *our* privacy practices for all PHI that *we* maintain, including information *we* created or received before *we* made the changes. When *we* make a significant change in *our* privacy practices, *we* will send notice to *our* plan subscribers. For more information about *our* privacy practices, please contact *us.*

As a *covered person*, *we* may use and disclose *your* PHI, without *your* consent/authorization in the following ways:

1. Treatment – *we* may disclose *your* PHI to a *health care practitioner*, a hospital or other entity which asks for it in order for *you* to receive medical treatment; and
2. Payment – *we* may use and disclose *your* PHI to pay claims for *covered expenses* provided to *you* by *health care practitioners*, hospitals or other entities.

We may also use and disclose *your* PHI to conduct other health care operations activities.

It has always been *our* goal to ensure the protection and integrity of *your* PHI. Therefore, *we* will notify *you* of any potential situations where *your* identification would be used for reasons other than treatment, payment and health plan operations.

Additional policyholder responsibilities

In addition to responsibilities outlined in the *policy*, the *policyholder* is responsible for:

- Collection of premium; and
- Providing access to:
  - Benefit plan documents;
  - Renewal notices and policy modification information;
  - Product discontinuance notices; and
  - Information regarding continuation rights.

No *policyholder* has the power to change or waive any provision of the *policy*.

Certificate of insurance
A *certificate* setting forth a statement of insurance protection to which the *employee* and the *employee's* covered *dependents* are entitled will be available via internet access or in writing when requested. The *policyholder* is responsible for providing *employees* access to the *certificate.*

Assignment
The *policy* and its benefits may not be assigned by the *policyholder*.

Conformity with statutes
Any provision of the *policy* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).

Modification of policy
This plan may be modified at any time by agreement between *us* and the *policyholder* without the consent of any *covered person.* Modifications will not be valid unless approved by *our* president, vice president, secretary or other authorized officer. The approval must be endorsed on, or attached to, the *policy.* No agent has the authority to modify the *policy,* waive any of the *policy* provisions, extend the time for premium payment, make or alter any contract, or waive any of the Company's other rights or responsibilities.

The *policy* may be modified by *us* at any time without prior consent of, or notice to, the *policyholder* when the changes are:

- Allowed by state or federal law or regulation;
- Directed by the state agency that regulates insurance;
- Benefit increases that do not impact premium; or
- Corrections of clerical errors or clarifications that do not reduce benefits.

Modifications due to reasons other than those listed above, may be made by *us,* upon renewal of the *policy,* in accordance with state and federal law. The *policyholder* will be notified in writing or electronically at least 31 days prior to the effective date of such changes.

A note about this certificate – "benefit plan document"
This *certificate* is part of the insurance *policy* and describes the benefits, provisions and limitations of the *policy.* Nothing in this *certificate* waives or alters any of the terms or conditions of the *policy.* The final interpretation of any specific provision in this *certificate* is governed by the terms of the *policy.* In the event of conflict between the *policy* and this *certificate,* the provisions of the *policy* will prevail. The benefits outlined in this *certificate* are effective only if *you* are eligible for insurance, become insured and remain insured in accordance with the terms of the *policy.*

Claims

How we pay claims

Identification numbers

You will receive an electronic identification (ID) card showing *your* name, identification number and group number. Show this ID card to *your vision provider* when *you* receive *services.*

Notice of Claim

A written notice of claim must be given to us within 20 days after the expense incurred date of any loss covered by the policy. Failure to give notice within that time frame shall not invalidate nor reduce any claim if it shall be shown not to have been reasonable possible to give such notice and that notice was given as soon as reasonable possible.

Claim Forms and proof of loss

When we receive a claim, we will notify you or your vision provider if any additional information is needed. Upon receipt of notice of claim, we will send you the forms for filing proof of loss. If the forms are not sent to you within 15 days after we receive notice of any claim, you will be deemed to have met the proof of loss requirement upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Written proof of loss must be furnished to us within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Paying claims

We determine if *benefits* are available and pay promptly any amount due under this *policy* in the timeframe required by state law or by a *vision provider's* contract. This will not exceed 30 days after we receive written proof of loss. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the *vision provider* unless *you* have notified *us* in writing by the time the claim form is submitted.

Reasons for denying a claim

Below is a list of the most common reasons *we* cannot pay a claim. Claim payments may be limited or denied in accordance with any of the provisions contained in this *certificate.*

1. **Not a covered benefit:** The *service* is not a *covered service* under the *certificate.*

2. **Eligibility:** *You* no longer are eligible under the "Terminating Coverage" section of this *certificate,* or the *expense incurred* date was prior to *your* effective date.

3. **Fraud:** *You* make an intentional misrepresentation by not telling *us* the facts or withhold information necessary for *us* to administer this *certificate.*

   Insurance fraud is a crime. Anyone who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains false or deceptive information may be guilty of insurance fraud.

   If a *covered person* commits fraud against *us,* as determined by *us,* coverage ends automatically, without notice, on the date the fraud is committed. This termination may be retroactive. *We* also will provide information to the proper authorities and support any criminal charges that may be brought. Further, *we* reserve the right to seek civil remedies available to *us.*

We will not end coverage if, after investigating the matter, *we* determine that the *member* provided information in error. *We* will adjust premium or claim payment based on this new information.

If *you* provided correct information and *we* made a processing error, *you* will be eligible for coverage and claims payment for *covered expenses*. *We* will adjust *your* premium or claim payment based on the correct information.

Duplicating provisions: If any charge is described as covered under two or more benefit provisions, *we* will pay only under the provision allowing the greater *benefit.* This may require *us* to make a recalculation based on both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for *benefits* other than those this *certificate* provides.

Legal actions and limitations
You cannot bring a legal action to recover a claim until 60 days after the date written proof of loss is made. No action may be brought more than three years after proof of loss is made.

Physical examinations and autopsy
We, at our own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Facility of payment
Payments made under any other plan which, according to these provisions, should have been made by us, will be adjusted by us. To do this, we will pay the organization (s) which made such payments the amount (s) determined to be warranted. Any amount(s) so paid are regarded as benefits paid under this paid under this policy.

Clerical error, misstatement of age or gender
If it is determined that information about the age or gender of *you* or your *dependents* was omitted or misstated in error, the amount of insurance for which *you* are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to *you* and to *us.*

Right to collect needed information
You must cooperate with *us* and when asked, assist *us* by providing information *we* request to administer the policy.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.

Claims paid incorrectly
If a claim was paid in error, *we* have the right to recover *our* payments. *We* may correct this error by an adjustment to any amount applied to the deductible or *reimbursement limits.* Errors may include such actions as:

1. Claims paid for *services* that are not actually covered under the *policy.*
2. Claims payment that is more than the amount allowed under the *policy.*
3. Claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of *our* payments made in error from anyone to, for or with respect to whom such payments were made; or any insurance companies or organizations that provide other coverage for the *covered expenses*. *We* will determine from whom *we* shall seek recovery. For information on *our* process, see the Recovery rights provision.

If an error has been found which resulted in an underpayment of the claim by us, we will adjust the claim and additional payment will be made. If the original claim was paid to the vision provider, we will forward the adjustment to the vision provider also, unless we are notified that vision provider has been paid in full. In that case, we will make the additional payment to you.

Recovery rights

Your obligation in the recovery process

We have the right to collect our payments made in error up to one year from the date we made payment. *You* are obligated to cooperate and assist us and our agents to protect our recovery rights by:

1. Obtaining *our* consent before releasing any party from liability for payment of vision expenses.

2. Providing *us* with a copy of any legal notices arising from *your* injury and its treatment.

3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.

4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering."

If *you* fail to cooperate, *we* will collect from *you* any payments *we* made.

Cost of legal representation

The costs of our legal representation in matters related to our recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you,* unless we were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

Workers' compensation

If *we* pay *benefits* but determine that the *benefits* were for the treatment of bodily injury or sickness that arose from or was sustained in the course of any occupation or employment for compensation, profit or gain, *we* have the right to recover that payment. *We* will exercise *our* right to recover against *you.*

The recovery rights will be applied even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of, or resulted from, *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier; or

4. Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You agree that, in consideration for the coverage provided by the policy, *we* will be notified of any Workers' Compensation claim that *you* make, and *you* agree to reimburse *us* as described above.

Eligibility

When you are eligible for coverage

Employee coverage

Eligibility date: The *employee* is eligible for coverage when:

1. Eligibility requirements listed in the Employer Group Application (see *your employer* for details) are satisfied; and
2. *Employee* is in *active status.*

Effective date: The *employee's* effective date will be calculated after *we* receive the completed enrollment forms *we* furnish. The *employee's* Effective Date provision is outlined in the Employer Group Application (see *your employer* for details). *Your* effective date may be:

1. Immediately after the waiting period;
2. The first of the month after the waiting period; or
3. The date approved by *us.*

Employee delayed effective date: If the *employee* is not in *active status* on the effective date, coverage is effective on the day after the *employee* returns to *active status.* The *employer* must notify *us* in writing when an *employee* returns to *active status.*

Benefit changes: Benefit changes will become effective on the date specified by *us.*

Late applicant: If *you* enroll or are enrolled more than 31 days after *your* eligibility date, *you* will be considered a *late applicant*.

Incontestability: After two years from the effective date of the policy, no misstatement made by the *policyholder*, except a fraudulent misstatement made in the application may be used to void the *policy*.

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premium; or
- Any fraudulent misrepresentation made by *you.*

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*.

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you.* A copy of the form must be given to *you* or *your* beneficiary.

Dependent coverage

Eligibility date: If an *employee* is covered, the *employee's dependent* is eligible for coverage:

1. On the date the *employee* is eligible for coverage;
2. On the date of the *employee's* marriage (spouse and/or stepchildren);
3. On the date of birth of the *employee's* natural-born child; or
4. On the date a child is placed in the *employee's* home for adoption by the *employee.*

Dependents who become employed by the *employer* participating in this policy must apply for coverage as an eligible *employee*.

Eligibility

Enrollment: Check with the *employer* on how to enroll for *dependent* coverage. Late enrollment may reduce *benefits*. The *employee* must enroll for *dependent* coverage and enroll additional *dependents* on enrollment forms *we* furnish.

Effective date: Each *dependent's* effective date of coverage is determined as follows, subject to the Dependent Delayed Effective Date provision:

1. If *we* receive the enrollment form before the *dependent's* eligibility date, the *dependent* is covered on the date he or she is eligible.

2. If *we* receive the enrollment form within 31 days after the *dependent's* eligibility date:
   - The *dependent* is covered on the date *we* receive the completed enrollment form; or
   - The *dependent* is covered on the date he or she is eligible if the *employee* already had *dependent* coverage in force.

3. If *we* receive the completed enrollment forms more than 31 days after the *dependent's* eligibility date the *dependent* is covered on the date *we* specify.

A *dependent's* effective date cannot occur before the *employee's* effective date of coverage.

Dependent delayed effective date: A *dependent's* effective date of coverage will be delayed if the *dependent* is homebound due to bodily injury or sickness, or is confined to a hospital or mental health center. The *dependent's* coverage will be effective one day after discharge from confinement. A physician must certify the discharge.

Late applicant: If *you* enroll or are enrolled more than 31 days after *your* eligibility date, *you* will be considered a *late applicant*.

Retired employee coverage

Eligibility date: Retired *employees* are considered an eligible class if requested in the Employer Group Application and approved by *us.* Retired *employees* are eligible for coverage when the eligibility requirements in the Employer Group Application are satisfied.

Effective date: Retired *employees* must enroll for coverage on forms *we* furnish. The effective date of coverage for an eligible retired *employee* is the latter of:

1. The date retired *employees* are eligible for coverage under this policy;
2. The actual retirement date for *employees* who retire after that date; or
3. The date *we* specify if *we* receive the enrollment forms more than 31 days after the retired *employee's* eligibility date.

Retired employee delayed effective date: A retired *employee's* effective date of coverage will be delayed if the person is homebound due to bodily injury or sickness; or is confined to a hospital or mental health center. Coverage will be effective one day after discharge from confinement. A physician must certify the discharge. A decrease in insurance will be effective on the approved date of change.

Late applicant: If *you* enroll or are enrolled more than 31 days after *your* eligibility date, *you* are considered a *late applicant*.

Terminating coverage

Your insurance coverage may end at any time, as stated below and in the "Employer Group Application." Coverage terminates on the earliest of the following events:

1. Termination date listed in the *policy*;
2. The date premiums are not paid by the required due date;
3. The date the *employer* stops participating in the *policy*;
4. The date *you* enter the military fulltime. Upon notice to us of entry into such service, the pro rata unearned premiums shall be refunded. *Your* coverage may be reinstated after discharge from the military without showing evidence of insurability.
5. When *you* no longer are eligible for coverage as outlined in the "Employer Group Application;"
6. The date *you* terminate employment with the *employer*;
7. For a *dependent,* the date the *employee's* insurance terminates;
8. For a *dependent*, the end of the month he/she no longer meets the definition of a *dependent*;
9. The date an *employee* requests that insurance be terminated for the *employee* and/or *dependents*;
10. An *employee's* retirement date unless the "Employer Group Application" provides coverage for retirees; or
11. For any *benefit* that may be deleted from the policy, the date it is deleted.

You and the *employer* are responsible to notify *us* of any change in eligibility, including the lack of eligibility, of any *covered person.*

Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

1. If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person.* Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* for those services.
2. If *you* or the *policyholder* perpetrate fraud and/or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim, identification card or other identification.

Special provisions for active status

If the *employer* continues coverage under this policy, *your* coverage remains in force for no longer than three consecutive months if the *employee* is:

1. Temporarily laid off;
2. Temporarily in part-time status; or
3. On an *employer*-approved leave of absence.

All premiums must be submitted to *us* through the *employer*.

Continuation for specific circumstances

If *you* belong to a COBRA eligible group (employers with 20 or more employees), continuation may be available to the following members:

1. Surviving spouses;
2. Divorced or legally separated spouses; and
3. Eligible dependents.

Any member, whose coverage would otherwise terminate because of the dissolution of marriage or legal separation, or death of the employee, may continue coverage under this policy if you, the legally separated, divorced or surviving spouse are 55 years of age or older at the time of the expiration of coverage provided by the federal Consolidated Omnibus Reconciliation Act (COBRA).

Within 60 days of legal separation or the dissolution of marriage, or prior to the expiration of a thirty-six month COBRA continuation period covering a legally separated or divorced spouse who has elected and maintained such COBRA coverage, you must give written notice of the legal separation or dissolution of marriage to the employer. The notice shall include the mailing address of the legally separated or divorced spouse.

Within 30 days of the death of the employee, or prior to the expiration of a thirty-six month COBRA continuation period covering the surviving spouse, you must give the employer written notice of death and the mailing address of the surviving spouse.

Within 14 days of receipt of notice of the dissolution of marriage, legal separation, or death of the employee, a form for election to continue coverage will be sent to the legally separated, divorced or surviving spouse. A statement of the amount of periodic premiums for the continuation of coverage and method and place of payment will be included.

The monthly premium for the continuation will not be greater than 102% of the total of the following:

1. The amount you would be charged if you were a current group member; and
2. The amount your employer would contribute toward the premium, if you were a current group member.

You must pay the first premium for the continuation of coverage under this provision within 45 days of the date following election.

You must return the election form by mail within 60 days after the date the notice to elect continuation is mailed to you. Failure of the legally separated, divorced, or surviving spouse to exercise the election within such 60-day period will terminate the right to continuation of benefits under this provision.

Your right to continuation of coverage under this provision will terminate on the earliest of the following:

1. The end of the period for which you fail to make timely payment of premium;
2. The date your employer's group policy is terminated and NOT replaced; (If the group policy is replaced, coverage may continue under the new group policy as if the original policy had not terminated.)
3. The date you become insured under any other group health plan;
4. The date you remarry and become insured under any other group health plan; or
5. The date you become 65 years of age.

Replacement provisions

Applicability: This provision applies only if:

1. *You* are eligible for vision coverage on *your employer's* effective date under this policy; and
2. *You* were covered on the final day of coverage on *your employer's* previous group vision plan (Prior Plan).

Delayed effective date: *We* will waive the "Delayed Effective Date" provision if it applies to *you* when *you* would otherwise be eligible for vision coverage on *your employer's* effective date under this policy. Vision coverage is provided to *you* until the earlier of the following dates:

1. 90 days after *your employer's* effective date under this plan.
2. The date *your* vision coverage would otherwise terminate according to the "Terminating coverage" section in the *certificate.*

If *you* satisfy the "Delayed Effective Date" provision before either of these dates, *your* vision coverage will continue uninterrupted.

Definitions

***Allowance*:** The maximum amount *we* will pay for a *covered service* as shown in the "Schedule".

Active status: The *employee* performs all of his or her duties on a regular full-time basis for the required number of hours per week shown on the Employer's Group Application, for 48 weeks per year. *Active status* applies to *employees* whether they perform their duties at the *employer's* business establishment or at another location when required to travel for job purposes; on each regular paid vacation day; and any regular non-working holiday if the *employee* is not *totally disabled* on his or her effective date of coverage. An *employee* is considered in *active status* if he or she was in *active status* on his or her last regular working day.

Benefit: The amount payable in accordance with the provisions of this plan.

Certificate: This benefit plan document, which outlines the benefits, provisions and limitations of the *policy*.

***Vision exam*:** An exam of the complete visual system which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and *provider* signature.

Contact lens fitting and follow-up: A diagnostic evaluation and fitting include contact lens compatibility tests, diagnostic evaluations and diagnostic lens analysis to determine a patient's suitability for contact lenses or a change in contact lenses. Procedures for the diagnostic evaluation may include:

1. Contact lens related history
2. Keratometry and/or corneal topography
3. Anterior segment analysis with dyes
4. Biomicroscopy of eye and adnexia
5. Biomicroscopy with diagnostic lenses
6. Over-refraction
7. Visual acuity with diagnostic lenses
8. Determination of contact lens specifications
9. Patient instructions and consultations
10. Proper documentation with assessment and plan.

Appropriate follow-up evaluations may include the following procedures:

1. contact lens history including a review of care and hygiene regimen
2. visual acuities
3. Over-refraction, as indicated
4. Keratometry and/or corneal topography as indicated
5. Evaluation of prescription contact lenses with appropriate instruments
6. Biomicroscopy of eyes and adnexia (with fluorescein or other dyes as indicated)
7. Consultation and proper documentation with assessment and plan.

Definitions

Copayment: The charge, in addition to premiums, which *members* are required to pay for certain *covered services* provided under the *policy.* A *copayment* is either expressed as a flat dollar amount, or a percentage of the *reimbursement limit.* The *member* must make *copayments* at the time of service directly to the provider.

Cosmetic service: *Services* provided primarily for the purpose of improving appearance.

Covered expense: The *reimbursement limit* for a *covered service.*

Covered person: An *employee* and/or the *employee's dependents* who are enrolled for benefits provided under the *policy.*

Covered service: A *service* considered *visually necessary or appropriate*, or routine, that is:

1. Ordered by a *vision provider*;
2. For the *benefits* described, subject to any *reimbursement limit,* as well as all other terms, provisions, limitations and exclusions of the policy; and
3. Incurred when a member is insured for that *benefit* under the policy on the date the *expense incurred* date.

Dependent: A covered employee's:

1. Lawful spouse; and
2. Unmarried, natural born child, step-child, legally adopted child, or child placed for adoption, whose age is less than the limiting age. Adopted child includes a child who is placed in the home of the insured for the purpose of adoption. Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Placement means in the physical custody of the adoptive parent. Coverage shall include any covered services treating medical conditions existing prior to the date of placement. Each child must qualify as a dependent as defined by the United States Internal Revenue Code.

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Under no circumstances shall dependent mean a grandchild, great grandchild, foster child or emancipated minor, including where the grandchild, great grandchild, foster child or emancipated minor meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age for each dependent child is 26 years.

A covered *dependent* child who reaches the limiting age while insured under this policy remains eligible for vision care service *benefits* if:

1. Incapable of self-sustaining employment by reason of mental or physical handicap and
2. Chiefly dependent on the covered *employee* for support and maintenance.

Proof of such incapacity and dependency must be furnished to us that the above conditions continually exist within 31 days after the dependent reaches the limiting age. *We* may not request proof more often than annually after two years from the date the first proof was furnished. If *we* do not receive proof, the child's coverage ends on the date proof is due.

Definitions

***Eligibility date*:** The date the *employee* or *dependent* is eligible to participate in the plan.

Employee: The person who is regularly employed and paid a salary or earnings and is in *active status* at the *employer's* place of business. If the *employer* is a union, the *employee* must be in good standing and eligible for insurance according to the union's rules of eligibility.

Employer: The *policyholder* of the group insurance plan, or any subsidiary described in the Employer Group Application.

Expense incurred: The amount *you* are charged for a *service.*

Family member: Anyone related to *you* by blood, marriage or adoption.

***Group*:** The persons for whom this insurance coverage has been arranged to be provided.

Health care practitioner: A practitioner professionally licensed by the appropriate state agency to diagnose or treat sickness or bodily injury and who provides services within the scope of that license.

***Materials*:** Lenses, frame, and contact lenses covered under this *policy*.

Member: The person covered under the *policy*. *Employees* and/or their covered *dependents.*

***Member Cost in Network*:** The amount of the *member's* responsibility for services provided by a *preferred provider*.

Non-preferred provider: A vision provider who has not entered into a service agreement with *us* nor has been designated by *us* to provide vision care services to covered persons.

***Out of Network Allowance*:** The benefit available to a *member* for services provided by a *non-preferred provider.*

***Policy*:** The document describing the benefits *we* provide as agreed to by *us* and the *policyholder*.

Policyholder: The legal entity named on the face page of the policy.

Preferred provider: A vision provider who has entered into a service agreement with *us* to provide vision care services to covered persons.

Definitions

Reimbursement limit is the maximum allowable fee for a *covered service.* It is the lesser of the charged amount, or:

1. In the case of *services* rendered by providers with whom *we* have agreements, the fee that *we* have negotiated with that *preferred provider*;
2. In the case of services rendered by providers with whom we do not have agreements, the amount shown in the Plan's *Non-Preferred Provider* Benefit on the schedule.

Services: Procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Total disability/totally disabled: An *employee* or employed covered spouse who, during the first 12 months of a disability, is prevented by *bodily injury* or *sickness* from performing all aspects of his or her respective job or occupation. After 12 months, *total disability/totally disabled* means the person is prevented by *bodily injury* or *sickness* from engaging in any paid job or occupation that he/she is reasonably qualified for by education, training or experience.

For any *member* who is not employed, *total disability* means a disability preventing him/her from performing the usual and customary activities of someone in good health of the same age and gender.

A *totally disabled* individual may not engage in any paid job or occupation.

Visually necessary or appropriate: Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative, as determined by *us.*

Vision provider: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials.

Waiting period: The period of time, elected by the *policyholder,* which must pass before an *employee* is eligible for coverage under the *policy.*

We, us and our: The insurance company as shown on the cover page of this *certificate.*

You and your: Any covered *employee* and/or *dependent(s).*

Humana.

Toll Free: 877-398-2980
1100 Employers Blvd.
Green Bay, WI 54344
Humana.com

INSURED BY
HUMANA INSURANCE COMPANY

Humana.

CONSUMER COMPLAINT NOTICE

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/Consumer Assistance/index.aspx

Policyholder: TIGER WATERFRONT PRODUCTS
Group Number: 836183
Type of coverage: MO HUMANA VISION 160,POLYCARB,12MO FRAME
Effective Date: 01-01-2020

Schedule of benefits

This summary provides an overview of plan *benefits*. Refer to *your* "Vision Benefits" provision{s} for detailed descriptions, including additional limitations or exclusions.

When services or materials are provided by *preferred providers, your* cost will be the cost shown in the Preferred Provider Benefit column shown in the Vision Benefits provision below.

When services or materials are provided by *non-preferred providers, we* will pay the lesser of the actual expense incurred or the *reimbursement limit* for each covered benefit.

If a benefit is subject to a frequency limitation, that limitation is calculated based on the length of time between dates of service.

Vision benefits

Service/Material	Frequency	Preferred Provider Benefit	Non-Preferred Provider Benefit
Routine Vision Examination w/dilation as necessary	1 per 12 months	$10 Copayment	$30 Allowance
Contact Lens Examination	1 per 12 months		
Standard Contact Lens Fit and Follow Up		$0 Copayment	$30 Allowance
Premium Contact Lens Fit and Follow Up		$55 Allowance	$30 Allowance
Frames	1 per 12 months	$160 Allowance	$80 Allowance
Standard Plastic Lenses	1 per 12 months		
Single Vision/Materials		$10 Copayment	$25 Allowance
Bifocal		$10 Copayment	$40 Allowance
Trifocal		$10 Copayment	$60 Allowance
Lenticular		$10 Copayment	$100 Allowance

Contact Lenses(in lieu of frames and lenses)	1 per 12 months		
Conventional		$160 Allowance	$128 Allowance
Disposable		$160 Allowance	$128 Allowance
Medically Necessary		Paid in Full	$210 Allowance
Lens Options		includes Lens Copay	
Standard Polycarbonate age 18 and younger		Paid in Full	Not Covered
Standard Anti-reflective Coating		$10 Copayment	$25 Allowance
Premium Anti-reflective Coating		$35 Allowance	$25 Allowance
Standard Progressive (add on to Bifocal)		$10 Copayment	$40 Allowance
Premium Progressive		$65 Allowance	$40 Allowance

Frames - The *preferred provider* will show the *covered person* the frames that this policy covers in full. If a *covered person* selects a frame that costs more than the amount covered under this *policy*, the *covered person* is responsible for the difference in cost. Where the vision exam shows new lenses or frames or both are a *visual necessity*, benefits for lenses and frames include (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; and (4) proper fitting and adjustments.

Lenses – Where the vision exam shows new lenses or frames or both are a *visual necessity*, benefits for lenses and frames include (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; and (4) proper fitting and adjustments.

Standard contact lens fit and follow-up – Includes spherical clear contact lenses in conventional wear and planned replacement.

Premium contact lens fit and follow-up - Includes all lens designs, *materials*, and specialty fittings other than standard contact lenses.

Contact Lenses
Contact lenses are provided in lieu of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the *covered person's* lens and frame benefits for the current benefit period and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current benefit period.

Contact lens materials when medically necessary – *We* will pay a benefit for one pair of contact lenses under the following circumstances and only if prior authorization from *us* is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) high ametropia of either +10D or -10D in any meridian; 4) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 5) Diagnosis of Keratoconus supported by medical record documentation consistent with a two line improvement of visual acuity with contact lenses as the treatment of choice; or 6) monocular aphakia and/or binocular aphakia where the provider certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in *your* "Vision Benefits" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.

2. *Services*:

    - That are free or that *you* would not be required to pay for if *you* did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;

    - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or

    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with sickness or bodily injury.

3. Any loss caused or contributed by:

    - War or any act of war, whether declared or not;

    - Any act of international armed conflict; or

    - Any conflict involving armed forces of any international authority.

4. Any expense arising from the completion of forms.

5. *Your* failure to keep an appointment.

6. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.

7. Prescription drugs or pre-medications, whether dispensed or prescribed.

8. Any *service* not specifically listed in the Schedule of Benefits.

9. Any *service* that *we* determine:

    - Is not a *visual necessity*;

    - Does not offer a favorable prognosis;

    - Does not have uniform professional endorsement; or

    - Is deemed to be experimental or investigational in nature.

10. Orthoptic or vision training.

11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service *we* consider *cosmetic*.
14. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates.
15. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
16. Charges exceeding the *reimbursement limit* for the *service*.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
35. Artistically painted lenses.

Supplemental Vision Expense Benefit

Diabetic EyeCare Benefit

Your certificate is amended to include this supplemental plan benefit. The effective date of the benefit is the latter of the effective date of *your certificate* or the date this benefit is added to *your certificate.* *Benefits* are subject to *visual necessity* and all policy terms, conditions and limitations.

The following benefit is added to *your certificate* as follows:

***We* will pay listed benefits for *covered expenses* for eye care related to diabetes as follows:**

Service/Material	Frequency	Preferred Provider Benefit	Non-Preferred Provider Benefit
Medical Office Visit	2 per year	Paid in Full	$77 Allowance
Retinal Imaging (not covered if extended ophthalmoscopy has been done in the last 6 months)	2 per year	Paid in Full	$50 Allowance
Extended Ophthalmoscopy (not covered if retinal imaging has been done in the last 6 months)	2 per year	Paid in Full	$15 Allowance
Gonioscopy	2 per year	Paid in Full	$15 Allowance
Scanning Laser	2 per year	Paid in Full	$33 Allowance

The following definitions are added to *your certificate*:

Office Service Visit (Medical Follow-up Exam) – means an office visit for the evaluation and management of an established patient. The office visit includes patient history, follow-up examination services as deemed appropriate by the provider, and medical decision making.

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report.

Gonioscopy means a procedure to look at the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Retinal Imaging Examination means the recording of a portion(s) or complete retina surface and structures.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral.

Supplemental Vision Expense Benefit

EXCLUSIONS
In addition to the Exclusions in the *certificate,* no benefits will be paid for services connected with or charges arising from:

1. any vision materials;

2. orthoptic or vision training, subnormal vision aids and any associated supplemental testing;

3. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures; or

4. any vision examination by a *policyholder* as a condition of employment.

Humana

Bruce Broussard
President

Change in Plan Rider: Open Enrollment

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your certificate* or the date this rider is added to *your certificate.* *Benefits* are subject to all *policy* terms, conditions and limitations, including *waiting periods,* if any.

Open enrollment period

The open enrollment period is the annual period during which eligible *employees* may apply for coverage for themselves and their eligible *dependents* as outlined in the **Employer Group Application** (see *your employer* for details).

To enroll for coverage

The *employee* must complete the enrollment/change form provided by *us,* carefully listing each person to be covered. Enrollment during the open enrollment period will be allowed if *we* receive the completed forms within the open enrollment period. Any reference to *late applicants* within the **Eligibility** section of *your certificate* and/or *policy* is removed. *Late applicants* are not eligible for coverage, and must wait until the following open enrollment period to apply.

The **When you are eligible for coverage** section in *your certificate* is amended as follows:

The eligibility date of coverage is amended to read:

Employee Coverage:

Eligibility date: The *employee* is eligible for coverage:

1. When eligibility requirements listed in the **Employer Group Application** (see *your employer* for details) are satisfied; and
2. When he or she is in *active status,* or;
3. On the *employer's* annual anniversary date.

Dependent coverage

Eligibility date: If an *employee* is covered, the *employee's dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage;
2. The date of the *employee's* marriage (spouse and/or stepchildren);
3. The date of birth of the *employee's* natural-born child;
4. The date a child is placed in the *employee's* home for adoption by the *employee,* or;
5. The *employer's* annual anniversary date.

Please check the **Schedule of benefits** section of this *certificate* for any *waiting periods* that may apply to *you.*

Humana

Bruce Broussard
President

Change in plan rider:
Coverage for domestic partners

Your certificate is amended to include this plan rider. The effective date of the rider is the latter of the effective date of *your* certificate or the date this rider is added to *your* certificate. *Benefits* are subject to all policy terms, conditions and limitations.

The following definitions are added to *your* certificate:

Domestic partners: The *employee* and another individual of the same or opposite sex who:

1. Cohabit, have done so for the previous six months and intend to do so indefinitely;
2. Have an exclusive mutual commitment to be jointly responsible for each other's common welfare and share financial obligations;
3. Are not related by blood to a degree of closeness that would prohibit legal marriage in the state where they legally live;
4. Are not married to, or legally separated from, anyone else;
5. Are not in another domestic partnership;
6. Are not in this domestic partnership solely to obtain insurance coverage;
7. Are both at least age 18 and competent to consent to contract; and
8. Have filed registration of a Declaration of Domestic Partnership, or its equivalent, in the city, county or state where they live, if it offers the ability for registration. If registration of a Declaration of Domestic Partnership or its equivalent is not available in *your* city, county or state, *we* reserve the right to require an affidavit from the domestic partners attesting that the above requirements are met.

We may periodically request that *you* furnish satisfactory proof to *us* that the requirements of *domestic partners* continue to be met. Domestic partners are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions. *Your domestic partner* may be identified as a spouse on identification cards or the certificate, however, *your domestic partner and your domestic partner's dependent child(ren)* are not eligible for COBRA or state continuation.

Domestic partner's dependent child: Any child:

1. Who lives with the *domestic partner* in a parent/child relationship;
2. Who is the *domestic partner's* unmarried natural blood related child, stepchild or legally adopted child;
3. Who is younger than the limiting age of a *dependent* child;
4. Who is primarily dependent upon the *domestic partner* for support;
5. Who is not covered by any other vision plan; and
6. Who is not entitled to coverage through another vision plan because of a Qualified Medical Child Support Order.

A *domestic partner's dependent child(ren)* are subject to all terms and provisions of the certificate including, but not limited to, all eligibility requirements and termination provisions.

Domestic partners

When you are eligible for coverage

In addition to the **Dependent coverage, Eligibility date** section in *your* certificate, the following applies to *domestic partners* and any *domestic partner's dependent child(ren):*

1. For the *employee's domestic partner,* the eligibility date will be the earlier of:
   - The date of registration of the Declaration of Domestic Partnership; or
   - The date the *employee* submits to the *employer* or *us* an affidavit attesting that a domestic partnership exists and all requirements of the definition of *domestic partner* are met.

2. For a *domestic partner's dependent child(ren)**:***
   - The eligibility date of the *employee's* domestic partner for any *domestic partner's dependent child(ren)* acquired on that date; or
   - The date the child meets the definition of a *domestic partner's dependent child.*

The effective date of a *domestic partner's dependent child* will not be before the effective date of the *employee's domestic partner.*

Terminating coverage

In addition to the **Terminating coverage** provision in *your* certificate, the following applies to *domestic partners* and any *domestic partner's dependent child(ren).*

The *employee's domestic partner* and any dependent child(ren) allowed eligibility will terminate on:

1. The date one of the *domestic partners* dies.
2. The date one of the *domestic partners* marries.
3. The earliest of the following:

   - The date one *domestic partner* gives or sends to the other partner a written notice that he or she is terminating the domestic partnership;
   - The date the *employee* submits to the *employer* notification to terminate the domestic partnership;
   - The date indicated on the Notice of Termination of Domestic Partnership or its equivalent, as filed in the city, county or state where the *domestic partners* live if it offers the ability to terminate a domestic partnership;
   - The date any of the requirements of the *domestic partner* definition is not met; or
   - For any *domestic partner's dependent child(ren),* the date any of the requirements of *domestic partner's dependent child(ren)* definition is not met.

The coverage of any *domestic partner's dependent child(ren)* will terminate upon termination of the *employee's domestic partner.*

Bruce Broussard
President

Notices

The following pages contain important information about certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. You are eligible for the rights more beneficial to you, unless preempted by state or federal law.

This section includes notices about:

Claims procedures

Federal legislation

- **Medical child support orders**
- **Continuation of coverage for full-time students during medical leave of absence**
- **General notice of COBRA continuation of coverage rights**
- **Family and Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights under ERISA**

Discrimination Notice

Claim procedures

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

1. Interpret plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

Claim procedures

Definitions

Adverse determination: means a decision to deny benefits for a pre-service claim or a post-service claim under a group health and/or dental plan.

Claimant: A covered person (or authorized representative) who files a claim.

Concurrent-care Decision: A decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan: an employee welfare benefit plan to the extent the plan provides dental care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer: the offering company listed on the face page of your Certificate of Insurance or Certificate of Coverage and referred to in this document as "Humana."

Post-service Claim: Any claim for a benefit under a group health plan that is not a Pre-service Claim.

Pre-service Claim: A request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care Claim (expedited review): A claim for covered services to which the application of the time periods for making non-urgent care determinations:

could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an Urgent-care Claim. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a " Urgent-care Claim" will be treated as a "claim involving urgent care."

Submitting a claim

This section describes how a Claimant files a claim for plan benefits.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense.
- Name and address of the provider
- Diagnosis
- Procedure or nature of the treatment
- Place of service
- Date of service
- Billed amount

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Procedural defects

If a Pre-service Claim submission is not made in accordance with the plan's requirements, Humana will notify the Claimant of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an Urgent-care Claim). If a Post-service Claim is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

- In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the Claimant within a reasonable time, as follows:

Pre-service claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the Claimant of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the necessary information.

Urgent-care claims (expedited review)

Humana will determine whether a particular claim is an Urgent-care Claim. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a Claimant to clarify the medical urgency and circumstances supporting the Urgent-care Claim for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the Urgent-care Claim.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the Claimant to provide the specified additional information.

Concurrent-care decisions

Humana will notify a Claimant of a Concurrent-care Decision involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination.

Humana will decide Urgent-care Claims involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a Claimant of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an Urgent-care Claim, the notice will provide a description of the plan's expedited review procedures.

Appeals of Adverse Determinations

A Claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A Claimant, on appeal, may request an expedited appeal of an adverse Urgent-care Claim decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

On appeal, a Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent-care Claims	As soon as possible but no later than 72 hours after Humana receives the appeal request.
Pre-service Claims	Within a reasonable period but no later than 30 days after Humana receives the appeal request.
Post-service Claims	Within a reasonable period but no later than 60 days after Humana receives the appeal request.
Concurrent-care Decisions	Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under section 502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the Claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

Exhaustion of remedies

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- provides for support of a covered employee's child;
- provides for health care coverage for that child;
- is made under state domestic relations law (including a community property law);
- relates to benefits under the group health plan; and
- is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act § 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

Continuation of coverage for full-time students during medical leave of absence

A dependent child who is in regular full-time attendance at an accredited secondary school, college or university, or licensed technical school continues to be eligible for coverage for until the earlier of the following if the dependent child takes a medically necessary leave of absence:

- Up to one year after the first day of the medically necessary leave of absence; or
- The date coverage would otherwise terminate under the plan.

We may require written certification from the dependent child's health care practitioner that the dependent child has a serious bodily injury or sickness requiring a medically necessary leave of absence.

General notice of COBRA continuation coverage rights

Introduction

You are getting this notice because you recently gained coverage under a group health and/or dental plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you too lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you too lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- the end of employment or reduction of hours of employment;
- death of the employee;
- commencement of a proceeding in bankruptcy with respect to the employer; or
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of

- ***continuation coverage*** **-** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of

- ***continuation coverage*** **-** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, or other laws affecting your group heath and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit at www.dol.gov/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA's website.)

Keep your plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed Services Employment and Reemployment Rights Act of 1994

Continuation of benefits
Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility
An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or

- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information
Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your Rights Under the Employment Rights Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called 'fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- if a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;
- if a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court:
- if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- if plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

  The Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue N.W.
  Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call the number on your ID card or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼（TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY: 711)。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد با شماره تلفن روی کارت شناسایی تان تماس بگیرید (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (رقم هاتف الصم والبكم: 711).

NOTICE OF PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 in hospital, medical, and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health
Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

Missouri Department of Insurance, Financial
Institutions and Professional Registration
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

Grievance procedures

We make every effort to resolve customer dissatisfaction issues at an informal level. *Our* customer service representatives are available to assist *you* with any issue relating to *your* vision coverage or any aspect of *your* plan. *We* can be reached at:

Humana Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
1-800-558-4444.

Definitions

The following terms are defined as they apply to this Grievance process:

Adverse determination: a determination made by *us* or *our* designated utilization review organization, that a proposed or delivered *service* has been reviewed and, based on the information provided, does not meet *your* plan requirements for *visual necessity,* appropriate or efficient and the payment for the requested *service* is either denied, reduced or terminated.

Grievance: any complaint submitted in writing, by *you* or a representative or provider on *your* behalf regarding:

1. Availability, delivery or quality of *services*, including a complaint regarding an adverse determination;
2. Claims payment, handling or reimbursement for services; or
3. Any issues related to *our* contractual relationship with *you.*

This correspondence should be submitted to:

Humana Correspondence Office
P.O. Box 14611
Lexington, KY 40512-4611

Grievance Review

You may wish to file a formal grievance. Formal grievances should be submitted as soon as possible following the occurrence.

First level

We will acknowledge the receipt of a formal grievance within 10 working days. *You* will be notified in writing of a final decision within 20 working days of receipt of the grievance. If the investigation cannot be completed within 20 working days, *you* will be notified in writing on or before the twentieth working day of the reasons for which additional time is needed. The investigation will be completed within 30 working days thereafter.

Within five working days of the investigation being completed, a person not involved in the grievance or the review will decide upon the appropriate resolution, and *you* will be notified in writing of the grievance resolution and the right to appeal to the Grievance Review Panel. *Our* written notice will clearly explain the resolution of the grievance and the right to request a second level of review.

Within 15 working days of the investigation being completed, *we* will notify the person who filed the grievance on *your* behalf of *our* resolution.

Second level -Grievance Review Panel

If *you* are not satisfied with the resolution of the formal grievance at the first level, *you* may appeal to the Grievance Review Panel by submitting a written request for review. The Grievance Review Panel will consist of:

1. Other enrollees;

2. *Our* staff providers or other providers not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and

3. Where the grievance involves an adverse determination, a majority of providers that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

The Grievance Review Panel request will be acknowledged within 10 working days of receipt. *You* will be given the opportunity to appear before the Grievance Review Panel to present *your* position.

The Grievance Review Panel will:

1. Review the initial determination and any additional evidence *you* submitted.

2. Notify *you* in writing of a final decision within 20 working days of receipt of the grievance. If the investigation cannot be completed within 20 working days, *you* will be notified in writing on or before the twentieth working day of the reasons for which additional time is needed. The investigation will be completed within 30 working days thereafter.

   Within five working days of the investigation being completed, a person not involved in the grievance or the review will decide upon the appropriate resolution and *you* will be notified in writing of the grievance resolution and the right to appeal to the Missouri Department of Insurance.

3. Notify the person who filed the grievance on *your* behalf of *our* resolution within 15 working days of the investigation being completed.

Expedited Review

An expedited review may be requested when review time frames would seriously jeopardize *your* life, health or ability to regain maximum function. *We* will accept requests for an expedited review, in writing or orally. If criteria are met for an expedited review, *we* will notify *you* verbally of the resolution within 72 hours. Written resolution will be sent within three working days.

If *you* are dissatisfied with the final decision or process, *you* have the right to appeal to the Missouri Department of Insurance during any phase of the grievance process. *We* will cooperate with *you* and the Department through this process.

Department of Insurance

You have the right to contact the Director of Insurance for assistance **at any time** at:

Missouri Department of Insurance
Room 530, Truman Building,
301 W High St.
Jefferson City, Missouri 65101

or

P.O. Box 690,
Jefferson City, Missouri 65102.
Telephone Number: Toll-Free 1-800-726-7390.