Administrative Office:
1100 Employers Boulevard
Green Bay, Wisconsin 54344

Group Vision Certificate of Insurance
Humana Health Benefit Plan of Louisiana

Policyholder: CLEMENT BUILDING COMPANY,

Policy Number: 677237

Effective Date: 01-01-2019

Product Name: LA HUMANA VISION 160

In accordance with the terms of the *policy* issued to the *policyholder,* Humana Health Benefit Plan of Louisiana 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* coverage

Table of contents

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 will void the *policy*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or electronic application and a copy is furnished to the person making such statement or his or beneficiary.

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.*

Submitting claim information and proof of loss

When *services* are rendered by a *preferred provider,* that provider will submit claim information.

When *services* are rendered by a *non-preferred provider, you* must submit the claim form directly to *us.* That claim form may be found on *our* website, **Humana.com**. Please contact the customer service number on *your* identification card if *you* have any questions regarding this process, or to request a paper copy.

We would like to receive this information within 90 days after the *expense incurred* date; however, the claim will not be reduced or denied if it was not reasonably possible to meet the 90-day guideline. In any event, *we* will need written proof of loss notice within one year after the date proof of loss is requested, except if *you* were legally incapacitated.

If *you* do not provide *us* with the necessary information, *we* will deny any related claims until *you* provide it to *us.*

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. *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. *Our* payments are made in good faith and will fully discharge *us* of any liability to the extent of such payment.

Payment of available *benefits* will be made within 30 days of written receipt of all information as required by the Submitting Claim Information and Proof of Loss section, unless there are just and reasonable grounds to delay payment.

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

No lawsuit with respect to plan benefits may be brought after the expiration of three years after the later of:

1. The date on which *we* first denied the service or claim; paid less than *you* believe appropriate; or failed to timely pay the claim; or
2. 180 days after a final determination of a timely filed appeal.

Conformity with state statutes

Any provisions which, on the Policy effective date, are in conflict with the laws of the state in which the Policy is issued shall not be rendered invalid, but shall be construed and applied in accordance with the minimum requirements of those laws.

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 *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.

Recovery rights

Your obligation in the recovery process

We have the right to collect *our* payments made in error. *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.

Right of subrogation

To the extent that benefits are provided or paid under this Policy, *we* shall be subrogated to all rights of recovery which any *member* may acquire against any other party for the recovery of the amount paid under this Policy, however our Right of Subrogation is secondary to the right of the *member* to be fully compensated for his damages. The *member* agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action *we* may require to facilitate enforcement of *our* Right of Subrogation. *We* agree to pay *our* portion of the *member's* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this Policy pursuant to *our* Right of Subrogation.

Right of reimbursement

To the extent *we* have paid benefits under this *policy*, *you* agree that if *you* recover from a third party, *you* will reimburse the portion of the damages recovered for the expenses incurred by *you* that were paid by *us*. *We* agree to pay *our* portion of *your* attorney's fees associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this policy pursuant to *our* right of reimbursement.

Assignment of recovery rights

If *your* claim against the other insurer is denied or partially paid, *we* will process the claim according to the terms and conditions of this policy. If *we* make payment on *your* behalf, *you* agree that any right for expenses *you* have against the other insurer for expenses *we* pay will be assigned to *us*.

If *benefits* are paid under this policy and *you* recover under any automobile, homeowners, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.

Continuation of Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an *employee*, *member*, subscriber, or retiree (or as that person's *dependent*) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation of Coverage During Military Leave

An *employee* who leaves employment to enter the armed services has a right to elect to continue his or her coverage under this Plan by furnishing the *policyholder* with sums equal to that which would have been deducted from his or her compensation for such coverage. The *employee* shall notify the *policyholder* of his or her election to continue coverage at the time the *employee* enters service in the uniformed services.

Covered *dependents* who are subsequently called to service in the uniformed services shall continue to be considered a *member* under this Plan without any lapse of coverage, provided that all required contributions are paid in accordance with Policy provisions.

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.

An independent incontestability period begins for each type of change in coverage or when a new employee enrollment form is completed.

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*.

Eligibility

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;
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*.

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*.

***Comprehensive eye 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. Natural blood related child or stepchild;
3. Child who is placed in the home of the *employee* pursuant to an adoption placement agreement executed with a licensed adoption agency, from the date of placement;
4. Grandchild who is in legal custody of the covered grandparent;
5. Child who is placed in the home of the *employee* following execution of an act of voluntary surrender in favor of the *employee* or the *employee's* legal representative, effective on the date on which the act of voluntary surrender becomes irrevocable; or
6. Child for whom you have received a court or administrative order to provide coverage until:
    a. *You* or *your dependent* child are no longer eligible under the Policy; or
    b. Such court or administrative order is no longer in effect; or
7. The child is enrolled for comparable health coverage which is effective no later than the termination of the child's coverage under the Policy.

The limiting age for each *dependent* child is the child's 26 birthday.

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

1 Mentally or physically disabled;
2 Incapable of self-sustaining employment; and
3 Chiefly dependent on the *employee* for support and maintenance.

You need to provide *us* with satisfactory proof that the above conditions continually exist 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 satisfactory proof, the child's coverage ends on the date proof is due.

Definitions

***Electronic or electronically*:** Relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic mail: A computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

***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: Humana Health Benefit Plan of Louisiana.

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 Health Benefit Plan of Louisiana

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: CLEMENT BUILDING COMPANY,
Group Number: 677237
Type of coverage: LA HUMANA VISION 160
Effective Date: 01-01-2019

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 24 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 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

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA

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.

Supplemental Vision Expense Benefit

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

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

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA

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

Notice of Non-Insured Benefits

Discount/access disclosure

From time to time, *we* may offer or provide *you* with additional goods and/or services that are not related to the benefits provided under the Policy. In addition, *we* may arrange for third-party service providers to provide you with discounts on goods and services. Some of these third party service providers may make payments to *us* when these discount programs are used.

These payments offset the cost to us of making these programs available and may help reduce the costs of *your* plan administration.

Who has responsibility for these discounts?

Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under the Policy. The third-party providers are solely responsible for providing the goods and/ or services. *We* are not responsible for any goods and/ or services nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable for the negligent provision of such goods and/ or services by third-party service providers.

Discount programs may not be available to people who "opt out" of marketing communications, or where otherwise restricted by law.

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).

Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association (the LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, the LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the LLHIGA is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of under some types of policies if the insurer becomes impaired or insolvent.

<u>COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY</u>. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

Louisiana Life and Health
Insurance Guaranty Association
PO Drawer 44126
Baton Rouge, Louisiana 70804

Louisiana Department of Insurance
PO Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act (the law). The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health or annuity policy or contract, a certificate under a direct group policy, or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state unless they are afforded coverage by the guaranty association of another state, or circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by the LLHIGA if:

1. they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2. the insurer was not authorized to do business in this state;
3. their policy was issued by a profit or non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

The LLHIGA also does not provide coverage for:

1. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. any policy of reinsurance (unless an assumption certificate was issued);
3. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
4. dividends, premium refunds, or similar fees or allowances described under the law;
5. credits given in connection with the administration of a policy by a group contract holder;
6. employers', associations', or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
7. unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans under Section 403(b) of the Internal Revenue Code (26 U.S.C. §403(b));
8. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
9. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C Coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
10. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association also limits the amount the LLHIGA is obligated to pay out. The benefits for which the LLHIGA may become liable shall in no event exceed the lesser of the following:

1. the LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
2. for any one insured life, regardless of the number of policies or contracts there are with the same company, the LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
3. for any one insured life, regardless of the number of policies or contracts there are with the same company, the LLHIGA will pay a maximum of $500,000 in health insurance benefits and the LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, the LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any on individual.