

# HUMANA<sup>®</sup>

*Specialty Benefits*

Administrative Office:  
1100 Employers Boulevard  
Green Bay, Wisconsin 54344

## Vision Plan Certificate of Insurance Humana Insurance Company

**Policyholder:** GEORGIA COLLEGE AND STATE UNIVERSITY  
**Policy Number:** 530323  
**Effective Date:** 01/01/2010  
**Product Name:** GA VOLUNTARY HUMANAVISION FOCUS

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



Michael B. McCallister  
President

**NOTICE:**  
**BENEFITS UNDER THIS PPO PLAN ARE LIMITED WHEN YOU SEE A NON-NETWORK PROVIDER**

The benefits in this PPO plan are designed to allow you to realize a lower member cost when you receive your services from a network provider. When your treatment is provided by a non-network provider you will have a higher member cost. Please review your schedules of benefits carefully to understand this difference in benefits.

**EMERGENCY CARE**

If you receive emergency care and cannot reasonably access care from your network provider, benefits for that emergency care rendered during the course of the emergency will be payable at the network provider benefit percentages. However, if you could have reasonably reached a network provider, benefits will be payable at the non-network provider benefit percentages.

The insurance *policy* under which this *certificate* is issued is not 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 not a policy of Long Term Care insurance.

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

# Table of contents

<b>Benefits .....</b>	<b>4</b>
<b>Your plan benefits .....</b>	<b>4</b>
<b>Limitations &amp; exclusions (all services).....</b>	<b>6</b>
<b>How your plan works .....</b>	<b>8</b>
<b>Claims .....</b>	<b>12</b>
<b>How we pay claims .....</b>	<b>12</b>
<b>Recovery Rights.....</b>	<b>15</b>
<b>Eligibility .....</b>	<b>17</b>
<b>When you are eligible for coverage.....</b>	<b>17</b>
<b>Terminating coverage .....</b>	<b>19</b>
<b>Replacement provisions .....</b>	<b>20</b>
<b>Definitions.....</b>	<b>21</b>
<b>Open Enrollment .....</b>	<b>26</b>

# Benefits

Policyholder (Employer): GEORGIA COLLEGE AND STATE UNIVERSITY  
Group Number: 530323  
Coverage Effective Date: 01/01/2010

## Summary of your 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 in-network providers, *your* cost will be the Member Cost In Network shown in *your* Vision Benefits provision.

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.

**Please Note:** In-network benefits listed below are shown in terms of the amount the member would be responsible to pay. This amount is listed under the heading “Member Cost in Network”.

Benefits for services received from providers outside of the network are shown in terms of the amount *we* will reimburse *you* for that service, not the total amount you are responsible for. The total member responsibility will be the difference between the amount *we* will reimburse and the amount charged by the provider. The amount *we* will pay is found under the heading “Out-of-Network Allowance.”

## Vision benefits

### Professional Services

<u>Service</u>	<u>Member Cost in Network</u>	<u>Out-of -Network Allowance</u>
1 every 12 months		
Comprehensive Vision Examination	\$10 Copayment	\$35

### Materials:

Benefits for spectacle lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying the accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

# Benefits

<u>Material</u>	<u>Member Cost in Network</u>	<u>Out-of-Network Allowance</u>
<b><u>Lenses</u></b>		
1 set every 12 months		
Single lenses (plastic)	\$25 Copayment	\$25
Bifocal (plastic)	\$25 Copayment	\$40
Trifocal (plastic)	\$25 Copayment	\$55
<b><u>Lens Options</u></b>		
Basic Polycarbonate for members 19 years old and older.	\$40 Copayment	\$0
Basic Polycarbonate for members under the age of 19.	\$0 Copayment	\$0
<b><u>Frames</u></b>		
1 every 24 months	\$100 allowance	\$50
<b><u>Contact Lenses</u></b>		
1 pair every 12 months. Contact lenses are provided in lieu of all other lens benefits available herein. This means that utilization of contact lens benefits exhausts all of the <i>covered person's</i> lens benefits for the current benefit period and future eligibility for lenses will be determined as if spectacle lenses were obtained in the current benefit period.		
Conventional contact lenses are designed to be used until unsuitable for ongoing use and wear.		
Planned replacement lenses are those designed and labeled to be replaced at specified time intervals. They include disposable, daily disposable, one-month and three-month contact lenses.		
Medically necessary contact lenses are contact lenses that provide improved visual outcomes when compared to conventional spectacle lenses.		
Conventional	\$115 allowance	up to \$92
Planned Replacement	\$115 allowance	up to \$92
Medically necessary	\$0 copayment	up to \$200

# Benefits

## 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 anesthesiologist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any *service* not specifically listed in Your Plan 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*.

# Benefits

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 or safety eyewear, unless covered under this *policy*.
22. Two pair of glasses in lieu of bifocals
23. Services or materials provided by any other group benefit plans providing vision care.
24. Certain name brands when manufacturer imposes no discount.
25. Corrective vision treatment of an experimental nature
26. Pathological treatment
27. Non-prescription items
28. Costs associated with securing materials
29. Pre- and Post-operative services
30. Orthokeratology
31. Routine maintenance of materials
32. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the *certificate*.
33. Artistically painted lenses

# Benefits

## 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 Summary of Your 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 Summary of Your 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 [www.humana.com](http://www.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.

# Benefits

## 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.*

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.

# Benefits

## **Additional policyholder responsibilities**

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

1. Collection of premium; and
2. 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 *member*. 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 anytime without prior consent of, or notice to, the *policyholder* when the changes are:

1. Allowed by state or federal law or regulation;
2. Directed by the state agency that regulates insurance;
3. Benefit increases that do not impact premium; or
4. 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 60 days prior to the effective date of such changes. Payment of premium after the effective date of such change constitutes the *Policyholder's* consent to the change.

# Benefits

## **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*.

## How we pay claims

### Identification numbers

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

### Claim forms

Written notice of a claim must be given to *us* within 20 days of the *expense incurred* date. Failure to give notice with this time will not reduce the claim if notice of claim was given as soon as was reasonably possible.

Upon receipt of notice of claim, *we* will send to *you* the forms for filing Proof of Loss. If the forms are not sent to *you* within ten (10) days, *you* will have met the Proof of Loss requirement by sending to *us* a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

### 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, [www.humana.com](http://www.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 *vision providers* 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.

### Time of benefit payment

Payments due under this Policy will be paid upon receipt of written proof of loss.

If *we* fail to provide benefits payable under this Policy upon receipt of written proof of loss, *we* shall have 15 working days thereafter to send *you* a letter or notice which:

1. States the reason(s) *we* have not paid the claim; and
2. Gives written itemization of any documents or other information needed to process the claim.

# Claims

When all of the listed documents or other information needed to process the claim has been received, *we* shall have 15 working days thereafter to either pay or deny the claim and give *you* the reasons if there is a denial.

Claims not paid as above will be increased by interest of 18 percent per annum on the proceeds or benefits due under the terms of this Policy.

## 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 *member* 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 latter 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.

## 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*.

# Claims

## **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

*You* agree to transfer any rights to *us* that *you* have to recover any expenses paid under this policy. *We* will be subrogated to these recovery rights from any funds paid or payable.

*We* may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled. If *we* are precluded from exercising *our* subrogation rights, *we* may exercise *our* right of reimbursement.

### Right of reimbursement; coverage voided by non cooperation

If *you* or *your* covered *dependent* has a claim for damages or a right to recover damages from a third party or parties for any sickness or bodily injury for which benefits are payable under this plan, *we* may have the Right of Recovery. *Our* Right of Recovery shall be limited to the recovery of any benefits paid for identical medical or dental expenses under this Plan, but shall not include medical/dental items. Money received for future medical/dental care or pain and suffering may not be recovered. *Our* Right of Recovery may include compromise settlements. *You* or *your* attorney must inform *us* of any legal action or settlement agreement at least ten days prior to settlement or trial. *We* will then notify *you* of the amount *we* seek to recover for covered benefits paid. *Our* recovery may be reduced by the pro-rata share of *your* attorney’s fees and expenses of litigation.

### 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* as per the limits of the Right of reimbursement provision.

### 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*.

# Claims

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*.

**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:

1. Nonpayment of premium; or
2. 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 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;
4. On the date a child is placed in the *employee's* home for purpose of adoption by the *employee* or the date the child is legally adopted by the *employee*, whichever occurs first or
5. On the date specified in the court or administrative order, which requires the *employee* to provide coverage for the child or spouse as specified in such order, if *you* are eligible for dependent coverage.

*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. The date *we* specify if *we* receive the completed enrollment forms more than 31 days after the *dependent's* eligibility date.

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.

## 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.

# 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. Failure to pay premium 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. *You* terminate employment with the *employer*;
7. For a *dependent*, the date the *employee’s* insurance terminates;
8. For a *dependent*, the date he/she no longer meets the definition of a *dependent*;
9. The date an *employee* requests in writing, 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*.

# Eligibility

## 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

**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 Vision Examination:** A general evaluation of the complete visual system.

**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.

**Copayment:** The charge, in addition to premiums or subscription fees, which *members* are required to pay for certain *covered services* provided under the Contract. 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*.

# Definitions

**Covered service:** A service considered *visually necessary or appropriate*, medically necessary, 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;
2. Unmarried, natural blood related child, stepchild or legally adopted child including a child placed with the *employee* for adoption whose age is less than the limiting age;
3. Unmarried grandchild or great grandchild if a written power of attorney exists that gives a grandparent authority to act on behalf of the grandchild. A parent of a minor child may delegate to any grandparent residing in the state care giving authority regarding the minor child when hardship prevents the parent from caring for the child; or
4. Unmarried child whose age is less than the limiting age and for whom the *employee* has received a court or administrative order to provide coverage, if *you* are eligible for family coverage, until:
  - Such court or administrative order is no longer in effect; or
  - The child is enrolled for comparable coverage, which is effective no later than the termination of the child's coverage under the Policy.

Each child, other than those who qualify under a court or administrative order, must meet all of the qualifications of a *dependent*.

The limiting age for each *dependent* child is:

1. 19 years; or
2. 26 years if the child:
  - Was enrolled for a minimum of five months per calendar year as a full-time student at an accredited secondary school, college or university. A *dependent* child enrolled as a full-time student must have sufficient course credits to maintain full-time status as defined by such school; or
  - Was eligible to enroll as a full-time student at an accredited secondary school, college or university but was unable to enroll due to *bodily injury* or *sickness*.

*You* must furnish satisfactory proof to us upon *our* request that the above conditions continuously exist. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who becomes an *employee* eligible for other group coverage no longer is eligible for coverage under this *policy*.

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

1. Mentally retarded or physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a *dependent* and;
4. Unmarried.

# Definitions

*You* need to provide *us* with satisfactory proof, upon *our* request, 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 will not continue beyond the last date of eligibility

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

# Definitions

**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.

**Member:** *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.

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

1. For contracted providers, the fee or discount *we* have contracted with that provider;
2. In the case of services rendered by providers with whom we do not have agreements, the amount shown in the Plan's *Out-of-Network Allowance* schedule

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

# Definitions

**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:** Means Humana Insurance Company.

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

# Change in Plan Rider: Open Enrollment

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

## **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:

When eligibility requirements listed in the **Employer Group Application** (see *your employer* for details) are satisfied; and

When he or she is in *active status*, or;

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 purpose of adoption by the *employee* or the date the child is legally adopted by the *employee*, whichever occurs first;
5. The date specified in the court or administrative order, which requires the *employee* to provide coverage for the child or spouse as specified in such order, if you are eligible for dependent coverage, or;
6. The *employer's* annual anniversary date.

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



Gerald L. Ganoni  
President



**HUMANA<sup>®</sup>**

*Specialty Benefits*

Toll Free: 800-558-4444

1100 Employers Blvd.

Green Bay, WI 54344

**HumanaVisionCare.com**

INSURED BY  
HUMANA INSURANCE COMPANY

## **NOTICE**

**The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.**

## **Notices**

**The following pages contain important information about Humana's claims procedures and 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. The Plan participant is eligible for the rights more beneficial to the participant.**

This section includes notices about:

**Claims and Appeal 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**

**Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**

**Family And Medical Leave Act (FMLA)**

**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

**Your Rights Under ERISA**

**Privacy and Confidentiality Statement**

## **CLAIMS AND APPEALS 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.

## CLAIMS 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 of 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: (a) provides for support of a covered employee's child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the group health plan; and (e) 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 section 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 receiving this notice because you have recently become covered under a group health and/or dental plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's benefit plan document or contact the Plan Administrator.

### **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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, the 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 lose your coverage under the Plan because either one of the following qualified events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

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

- 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 divorce or legally separation from your spouse.

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

- 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."

### **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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

**For the 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. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two 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 the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60<sup>th</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

### **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the 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 Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group health 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 the EBSA website at [www.dol.gov/ebsa](http://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**

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

## **IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS**

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

**OPTION 1** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.

**OPTION 2** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

**Category 1** Medicare eligibles are:

- Covered employees in active service who are age 65 or older who choose Option 1;
- Age 65 or older covered spouses; and
- Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

**Category 2** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

- Retired employees and their spouses; or
- Covered dependents of a covered employee, other than his or her spouse.

### **Calculation and Payment of Benefits**

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

## **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 (USERRA)**

### ***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***

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

1. Twenty-four months beginning the first day of absence from employment due to service in the uniformed services; or
2. 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 ERISA**

Under the Employee Retirement Income Security Act of 1974 (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:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. 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.
3. 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 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. In addition, 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. 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 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

## **PRIVACY AND CONFIDENTIALITY STATEMENT**

We understand the importance of keeping your personal and health information private (PHI). 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:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- 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 health 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:

**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.

**Payment:** we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may 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 personal and health information. 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.