HUMANA INSURANCE COMPANY

P.O. Box 14313 **Lexington, KY 40512-4313** **(866) 537-0229**

CERTIFICATE

OF

GROUP VISION INSURANCE

This Certificate outlines the features of the Group Vision Insurance Policy issued to the Policyholder by Humana Insurance Company (hereinafter referred to as "Humana"). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (866) 537-0229.

Signed for Humana Insurance Company

Michael B. McCallister
President

SECTION I- DEFINITIONS

Copayment- means the amount an Insured is required to pay when a covered service is rendered or covered Materials are purchased. The Insured must make Copayments at the time of service directly to a Network Provider.

Dependent- means any of the following persons:

1. Your lawful spouse;
2. Your unmarried child who is no more than 25 years of age and not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.;
3. Your child who upon attainment of the limiting age while insured under the Policy is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Primary Insured for support and maintenance. Proof of such incapacity and dependency must be furnished to Us by the Primary Insured at least thirty-one days after the child's attainment of the limiting age. We may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, We may require subsequent proof not more than once each year.
4. A child includes adopted children, a child placed for adoption, as well as stepchildren or foster children living with the Primary Insured in a parent-child relationship.

We will not deny enrollment of a child on the grounds that:

1. The child was born out of wedlock; or
2. The child is not claimed as a dependent on the parent's federal income tax return; or
3. The child does not reside with the parent or in Our service area.

Effective Date – The date coverage under the Policy begins.

Insured- means You and Your Dependent(s) covered under the Policy.

Materials- means lenses, frame and contact lenses covered under the Policy.

Network Provider- means a provider under agreement with Us to provide certain vision services and Materials to Insureds at contracted rates and terms.

Non-Network Provider- means any provider who is NOT under agreement with Us to provide certain vision services and Materials to Insureds at contracted rates and terms.

Policy- means the Policy issued to the Policyholder.

Policyholder – means the entity to whom the Policy has been issued.

Primary Insured – means the person to whom this Certificate is issued.

Schedule of Benefits - means the listing of benefits showing what is paid.

Visual Necessity – means services and Materials medically or visually necessary to restore or maintain an Insured's visual acuity and health and for which there is a no less expensive professionally acceptable alternative, as determined by Us.

"**You**" and "**Your**" means the Primary Insured who is a member of the Policyholder.

"**We**", "**Our**", "**Us**", and "**Plan**" means Humana Insurance Company.

SECTION II-BECOMING INSURED

Effective Date - Your and/or Your Dependent(s) Effective Date of coverage will be calculated after We approve the completed application(s). Your and/or Your Dependent(s) effective date(s) will be the date approved by Us.

Newborn Child- A child born to You or Your Dependent spouse is covered from the moment of birth for 31 days. If you choose to insure Your newborn, You must enroll the child within 31 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 31-day period.

Adopted Child- A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 31 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.

Your Coverage Ends- Coverage for You and/or Your Dependent will end at 12:01 a.m. on the earlier of:

1. Subject to the Grace Period provision, the last day of the month for which a premium has been paid;
2. The date this Policy ends;
3. The date You or Your Dependent commits fraud or intentional misrepresentation of a material fact, as determined by Us;
4. For a Dependent, the last day of the month in which Your Dependent is no longer a Dependent as defined;
5. For a Dependent, the date Your insurance terminates; or
6. The last day of the month in which You request that insurance be terminated for You and/or Your Dependents provided coverage has been continuously inforce for at least 12 months from the Effective Date of the Policy.

If Your coverage ends it will not prejudice any existing claim.

SECTION III-PROCEDURES FOR USING BENEFITS

Provider Choice - The Insured may elect to receive services and Materials from either a Network Provider or a Non-Network Provider of his or her choice. When receiving services from a Non- Network Provider, You must obtain an Out-of-Network Claim Form located On our website www.myhumanavisioncare.com or You may call Customer Care at (866) 537-0229 and have the form mailed to You.

Using a Network Provider

Prior to receiving services, log on to Our website at www.humanavisioncare.com or call Customer Care (866)537-0229 to obtain a list of participating Network Providers and to confirm Your eligibility for benefits under the Policy.

Once You have verified that the provider is a participating Network Provider and confirmed that You are eligible for benefits, please contact the provider to schedule an appointment. You must identify yourself as a member, have Your group name and policy number available. The Network Provider will provide the covered service and bill the Plan directly. You will pay Your Copayment and any extra costs for services and materials not covered by the Plan.

In the event You receive a prescription for corrective eyewear from the examining Network Provider, You may obtain Materials from that provider or another participating Network Provider.

Using a Non-Network Provider - When an Insured elects to obtain services or purchase Materials from a Non-Network Provider, Our payment of benefits is based upon the allowance shown in the Schedule of Benefits. The Insured must pay the Non-Network Provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. The Insured is responsible for payment of the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits and any services or Materials NOT covered by the Policy.

SECTION IV-LIMITATIONS AND EXCLUSIONS

Limitations - In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits;
3. The negotiated fee when services are rendered by Network Providers; or
4. The allowance as shown in the Schedule of Benefits when services are rendered by Non-Network Providers.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;

unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions- We will not cover:

1. Orthopic or vision training and any associated supplemental testing.
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives.
3. Medical or surgical treatment of the eye, eyes or supporting structures.
4. Any services and/or Materials required by an employer as a condition of employment or safety eyewear, unless covered under the Policy.
5. Any injury or illness covered under any Workers' Compensation or similar law.
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses.
7. Charges incurred before the Insured's effective date or after the Insured's coverage under the Policy ends.
8. Contact lenses, except as specifically covered by the Policy.
9. Hi Index, aspheric and non-aspheric styles.
10. Oversized 61 and above lens or lenses.
11. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.
12. Services or Materials:
    a) 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;
    b) furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid);
    c) furnished by any U.S. government-owned or operated hospital/institution/agency for any service or Material connected with sickness or bodily injury.
13. 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.
14. Any services or Materials not listed as a covered benefit in the Schedule of Benefits.
15. Broken appointment fees.
16. Any expense arising from completion of forms.
17. Prescription drugs or medications, whether dispensed or prescribed.
18. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.

19. 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 non-conventional treatment or device.
20. Services provided by someone who ordinarily lives in the Insured's home or is related to the Insured by blood, marriage or adoption.
21. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
22. Pathological treatment.
23. Non-prescription Materials.
24. Costs associated with securing materials.
25. Pre- and post-operative services.
26. Orthokeratology.
27. Routine maintenance of Materials.
28. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the Policy.
29. Artistically painted lenses.

SECTION V-COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, vision care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Policy.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

This Plan determines its order of benefits using the first of the following rules which applies:

(a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
   (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.

(b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.

(d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. Humana has the right to decide which facts are needed. Humana may get needed facts from, or give them to, any other organization or person. Humana need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Humana any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, Humana may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Humana will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

7. ERRORS RELATED TO YOUR COVERAGE.

The Plan has the right to correct benefit payments made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payment if any underpayments have been made.

SECTION VI-PREMIUMS

Premium Payments - You must pay the required premium to Us as it becomes due. Failure to do so will result in termination of coverage.

The first premium is due on the Effective Date. Subsequent premiums are due on the first day of each premium period. Premium period means monthly or annually, as selected by You. All premiums are payable to Us at Our address.

Grace Periods - A grace period of 31 days is allowed for payment of each premium due after the first premium, during such grace period Your coverage under the Policy shall continue in force, unless You have given written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will charge a pro-rata premium for the time Your coverage under the Policy remained in force during such grace period.

Change in Premiums - Premiums are payable to Humana or Our authorized agent. We reserve the right to change premiums under the Policy on any premium due date by giving You not less than 60 days prior written notice.

SECTION VII-CLAIMS

Notice of Claim - Written notice of claim must be given to Us within 60-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 14313, Lexington, KY 40512-4313, or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

Claim Forms - You can get the forms You need for claiming benefits by calling Us at (866) 537-0229 or writing Us at P.O. Box 14313, Lexington, KY 40512-4313. If the forms are not sent to You before the expiration of 15 days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Time of Payment of Claims - Benefits payable under the Policy will be paid not more than 30 days after receipt of due written proof of such loss.

Proof of Loss – Written proof of loss must be furnished to Us at P.O. Box 14313, Lexington, KY 40512-4313 within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Legal Action - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

SECTION IX-GENERAL PROVISIONS

Representations and Warranties - All statements made by any Insured or the Policyholder are deemed representations and not warranties. No statement made by any Insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You, or in the event of Your death or incapacity, Your beneficiary or personal representative.

Worker's Compensation Act - The coverage under the Policy is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

Conformity with State Statutes - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Limit on Certain Defenses - After an Insured's coverage under the Policy has been in force for a period of two (2) consecutive years during the lifetime of the Insured, it shall become incontestable as to the statements contained in Your application for such Insured's coverage.

Notice of Independent Contractor Relationship –Network Providers are independent contractors, and We cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a Network Provider for any damages which result from any defective or dangerous condition in or about any facility in which services are rendered or from any Materials provided by a Network Provider.

Nothing contained in the Policy or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between the Insured and the Insured's vision providers regarding the Insured's condition or treatment options. When ordering services or Materials, vision providers and other providers are acting on the Insured's behalf. All decisions related to an Insured's care are the responsibility of the Insured and the treating provider, regardless of any coverage determination(s) We have made or will make. We are not responsible for any misstatement made by any provider with regard to the scope of covered expenses and/or non-covered expenses under the Policy and Your Certificate.

Modification of Policy – The Policy may be modified at any time by agreement between Us and the Policyholder without the consent of any Insured. 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 other reasons may be made by Us upon renewal of the Policy in accordance with applicable state and federal law. The Policyholder and You will be notified in writing or electronically at least (31) days prior to the effective date of such changes.

SCHEDULE OF BENEFITS

Vision Examinations - We will pay a benefit for a comprehensive eye examination once in any **12 month period**.

Lenses – We will pay a benefit for one pair of prescription lenses once in any **12 month period**. Where the vision examination shows new lenses or frames or both are a Visual Necessity, benefits for spectacle lenses and frames include (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; and (4) proper fitting and adjustments.

Frames - We will pay a benefit for one new frame once in any **24 month period**. The Network Provider will show the Insured the frames that the Plan covers in full. If an Insured selects a frame that costs more than the amount the Plan covers, the Insured is responsible for the difference in cost.

Contact lenses when necessary – We will pay a benefit for one pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month period** and only if prior authorization is obtained from the Plan.

Contact lenses when elective - We will pay a benefit for the combined cost of an annual vision exam, contact lens evaluation exam, fitting costs and contact lenses up to a maximum of $115.00. Payment will be IN LIEU OF ALL OTHER BENEFITS. Replacement will not be more often than once in any **12 month period**.

Co-Payment - An Insured's Co-payment is:

1.	Vision Examination	$10
2.	Materials	$25

Allowance – Vision charges received from Non-Network Providers will be paid by Us according to the following schedule.

Vision Examination	$35
Single Vision Lens	$25
Bifocal Lens	$40
Trifocal Lens	$60
Frame	$40
Contact Lenses when elective	$90*
Contact Lenses when necessary	$210*

*applies to professional services and materials

WHEN COVERED SERVICES ARE OBTAINED FROM A NETWORK PROVIDER, THE INSURED IS ONLY RESPONSIBLE FOR THE CO-PAYMENT AMOUNT LISTED ABOVE.

WHEN SERVICES ARE OBTAINED FROM A NON-NETWORK PROVIDER, PAYMENT OF BENEFITS IS BASED UPON THE ALLOWANCE.

Humana Insurance Company

AMENDATORY ENDORSEMENT
(Mississippi Residents Only)

This Amendatory Endorsement is attached to and made a part of your contract. It changes your coverage as follows:

A. Section VII – CLAIMS, Time of Payment of Claims, the following has been added:

Our receipt of written proof of loss (includes all medical and other information necessary for *us* to administer coordination of benefits and subrogation provisions) for a clean claim (or any clean portion thereof).

A claim (or any portion thereof) is "clean" if: no additional information, adjustment or alteration is required of the provider or the *primary insured* in order for *us* to process and pay *benefits*; and no defect, impropriety (including a lack of substantiating documentation) or particular circumstance requiring special treatment exists which prevents payment of *benefits* within the above stated time period.

A resubmitted claim (or any portion thereof) is clean if all deficiencies previously identified by *us* are corrected. Duplicate claims filed within 30 days of the original claim, fraudulently submitted claims, claims based on material misrepresentations, claims without information essential for *us* to administer coordination of benefits or subrogation provisions, claims submitted by a provider more than 30 days after the date of service, and claims submitted by the *primary insured* more than 30 days after the provider's billing date are not clean.

Within 35 days (25 days for electronic submissions) following *our* receipt of a claim (or any portion thereof) that is not clean, *we* will issue a written notice of deficiency to the provider (or the *primary insured* if not submitted by the provider), explaining the deficiencies and requesting all substantiating documentation and/or information required by *us* to adjudicate as a clean claim (or portion thereof) and pay benefits.

If *we* fail to pay benefits for a clean claim (or any clean portion thereof) or fail to issue a valid and proper notice of deficiency for a claim (or any portion thereof) within the above stated time periods, *we* will pay the provider (or the *primary insured* if not submitted by the provider) interest on any accrued unpaid benefits at the rate of 1-1/2% per month, accruing from the day after payment of any such unpaid benefits was due and until the claim (or portion thereof) is finally settled or adjudicated. If accrued interest totals less than $1.00, it will be credited to the provider's account (or the *primary insured's* account if not submitted by the provider).

If *we* fail to pay benefits for a clean claim (or any clean portion thereof) within the above stated time period, the provider (if submitted by the provider) and/or the *primary insured* may bring legal action to recover such benefits, any interest which may accrue as stated above, and any other damages as may be allowed by law.

Benefits are "paid" as of the date: *we* place cash or a cash equivalent (draft or other valid instrument) in the United States mail (or send by other means such as electronic transfer), in full satisfaction of the *benefits* determined to be due and payable under the *policy*, using a postage paid envelope properly addressed to the last known address of the provider (or the *primary insured* if not submitted by the provider); or, if not sent by United States mail, or not so posted, then on the date the *benefits* are delivered to the provider (or the *primary insured* if not submitted by the provider).

If any such benefits are payable to the estate of the *primary insured*, or if the *primary insured* is a minor or is, in *our* opinion, legally incapable of giving valid receipt and discharge of any payment, *we* may, at *our* option, pay an amount not exceeding $1,000.00 to any relative by blood or marriage of the *primary insured* or beneficiary, who is considered by *us* to be equitably entitled thereto. Any payment so made will constitute a complete discharge of *our* obligations to the extent of that payment, and *we* will not be required to see to the application of the money so paid.

B. Section VI – PREMIUMS, Change to Premiums, the last sentence pertaining to written notice has been deleted and replaced with the following:

We will provide written notice at least 60 days prior to the *effective date* of any premium change.

This Amendatory Endorsement is subject to all of the exceptions, definitions and conditions of the contract not inconsistent herewith. In all other respects, your contract remains the same.

Michael B. McCallister
President