HUMANA INSURANCE COMPANY

1100 Employers Blvd **Green Bay, WI 54344** **(877) 480-5669**

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 (800) 233-4013.

Right to Return Policy

If *you* are age 65 or older *you* have the right to return this *policy* within 30 calendar days of its initial delivery. If *you* choose to return this *policy* within the 30 day period, *we* will refund any money that *you* have paid for this insurance. If *you* return this *policy* within the 30 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *policy*. There will be no coverage for any claims incurred.

Signed for Humana Insurance Company

Leann M. Hutchinson
Vice 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.

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

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. The first of the month following the date You are first eligible for coverage;
2. The date We accept Your enrollment, if You are not enrolled within 30 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent's enrollment, if he is not enrolled within 30 days of becoming eligible.

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. The last day of the month that You and/or Your Dependent cease to be eligible for coverage;
2. The last day of the month in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which a premium has been paid; or
4. The date the Policy ends.

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.

Just before scheduling an appointment for vision care, the Insured must choose a Network Provider from the list of the network providers in the Insured's area. The Insured must call to schedule an appointment and give the Network Provider his/her name, the Insured's name, ID number and the name of the Group. After scheduling the appointment, the Network Provider's office verifies the Insured's eligibility and benefits before performing the exam. Upon completion of the exam, the Network Provider submits the claim form directly to the Plan for payment according to the Network Provider's agreement with the Plan. The Insured is responsible for any applicable Copayment and any extra costs for services and materials not covered by the Plan.

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. Photochromic 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. Orthoptic 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. Certain name brands when the manufacturer does not discount.
23. Pathological treatment.
24. Non-prescription Materials.
25. Costs associated with securing materials.
26. Pre- and post-operative services.

27. Orthokeratology.
28. Routine maintenance of Materials.
29. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the Policy.
30. 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 - All premiums are payable in advance for coverage under the Policy on the first day of each calendar month in accordance with the premium rate schedules of Humana in effect for each premium due date.

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 8504, Mason, OH 45040-7111, 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 (877) 480-5669 or writing Us at P.O. Box 8504, Mason, OH 45040-7111. 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 8504, Mason, OH 45040-7111 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 single, bifocal or trifocal plastic 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. Benefit for frames received from a Network Provider is limited to a maximum allowance of $100. The Network Provider will provide a discount of 20% off the balance over the maximum allowance. 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. 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.

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 cost of conventional contact lenses up to a maximum of $115 when received from a Network Provider. Payment will be IN LIEU OF ALL OTHER LENS BENEFITS. The Network Provider will provide a discount of 15% off the balance over the maximum amount for conventional contacts. Replacement will not be more often than once in any 12 month period.

Standard Contact Lens Fitting and Follow-up – The Insured is responsible for up to $40 of the standard contact lens fit and follow-up from a Network Provider, which includes spherical clear contact lenses in conventional wear and planned replacement once in any 12 month period.

Premium Contact Lens Fitting and Follow-up - includes all lens designs, materials and specialty fittings other than Standard Contact lenses once in any 12 month period. Benefit limited to a 10% discount off the Network Provider's retail price.

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

1.	Vision Examination	$10
2.	Lenses	$25

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

Vision Examination	$30
Single Vision Lens	$25
Bifocal Lens	$40
Trifocal Lens	$55
Frame	$50
Contact Lenses when elective	$92 (for conventional or disposable)
Contact Lenses when necessary	$200 (applies to materials only)

Humana Insurance Company

AMENDATORY ENDORSEMENT
(California Residents Only)

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

A. SECTION I - DEFINITIONS, the following changes are hereby made:

1. The definition of **Dependent**, item 3 is deleted and replaced with the following:

   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 a physically or mentally disabling injury, illness or condition, and chiefly dependent upon the Primary Insured for support and maintenance. We shall notify the Insured that the dependent child's coverage will terminate upon attainment of the limiting age unless the Insured submits proof of incapacity within 60 days of the date of receipt of the notification. We shall send this notification to the Insured at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the Insured for continued coverage of the child and proof of incapacity, We shall determine whether the dependent child meets that criteria before the child attains the limiting age. If We fail to make the determination by that date, We shall continue coverage of the child pending Our determination. 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.

2. Item 5 has been added to the **Dependent** definition:

   5. Domestic Partner

3. The following definition has been added:

   Domestic Partner – an adult who has chosen to share life with an Insured Person in an intimate and committed relationship of mutual caring. The domestic partnership must be established in California by the filing of a Declaration of Domestic Partnership with the Secretary of State and, at the time of filing, all of the following requirements must be met:
   a. Both persons have a common residence.
   b. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
   c. The two persons are not related by blood in a way that would prevent them from being married to each other in California.
   d. Both persons are at least 18 years of age.
   e. Either of the following:
      (i) Both persons are members of the same sex.
      (ii) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
   f. Both persons are capable of consenting to the domestic partnership.

   The forms entitled "Declaration of Domestic Partnership" and "Notice of Termination of Domestic Partnership" must be available to the public at the office of the California Secretary of State and each county clerk.

4. The definition of **Visual Necessity** is deleted in its entirety.

B. **SECTION II – BECOMING INSURED, Newborn Child and Adopted Child,** are deleted and replaced with the following:

If a Dependent child is born to or adopted by an Insured or Dependent spouse, the child will automatically be issued a separate policy (identical to this Policy) if the child is eligible as a Dependent. The effective date of coverage under the separate policy for the newly born or adopted child will be the moment of birth or placement for adoption (or, if earlier, the date of entry of an order granting custody of the child for purposes of adoption); and coverage under the separate policy will continue in force until the next premium due date or 31 days (whichever is later). Coverage under the separate policy will continue thereafter only if by that date the Company has been notified in writing and all premiums that are required under the separate policy have been paid (which will include premium for the first month's coverage) and the newly born or adopted child remains eligible as a dependent. Any Creditable Coverage available to a newly adopted child will apply to that separate policy. Coverage under the separate policy for the newly born or adopted child will terminate at the end of the Coverage Period selected by the Insured for this Policy.

If a Dependent, other than a newly born or adopted child, is confined in a Hospital as of 12:01 A.M. on the date he would otherwise become an insured Dependent, the date the Dependent will become covered will be deferred until the Dependent is discharged from the Hospital.

C. SECTION IV-LIMITATIONS AND EXCLUSIONS, **Exclusions** 9, 11 and 19 are deleted and replaced with the following:

9. Aspheric and non-aspheric styles.

11. Cosmetic Materials and services, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

19. Any service that is not a Visual Necessity.

D. SECTION V – COORDINATION WITH OTHER BENEFITS, 5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION, is deleted in its entirety.

E. SECTION VII - CLAIMS, **Time of Payment of Claims**, is deleted and replaced with the following:

Time of Payment of Claims

Indemnities payable under the policy for any loss will be paid immediately upon receipt of due written proof of loss, or if due written proof of loss is not received with a claim *we* will contest the claim within 30 business days of its receipt. If *we* fail to pay, deny or contest within those time periods, *we* will pay interest on any benefits payable at the rate of 10 percent per annum beginning on the first calendar day after the 30 business day period.

F. SECTION IX – GENERAL PROVISIONS, **Modification of Policy**, the following is added:

If such modification is made, We will forward an Amendatory Endorsement showing the modification to the Named Insured in physical form to be attached to his or her Certificate of Insurance.

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.

Leann M. Hutchinson
Vice President

Humana.

NOTICE TO INSUREDS REGARDING FILING OF COMPLAINTS

As our insured, your satisfaction is very important to us. If you have a question about your policy, if you need assistance with a problem, or if you have a claim, you should first contact your insurance agent or contact us at:

Humana Grievance & Appeals Office
P.O. Box 14638
Lexington, KY 40512-4516
(800)-233-4013

Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you have not received a satisfactory resolution to your problem from either your insurance agent or us, you may contact the California Department of Insurance with your complaint.

To contact the Department, write or call:

California Department of Insurance
Consumer Service Division
300 S Spring Street
Los Angeles, CA 90013
(800)-927-4357

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage. Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

● Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

● Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

● Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

● **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

● A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract

● A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society

● If the person is provided coverage by the guaranty association of another state

● Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual

● Employer and association plans, to the extent they are self-funded or uninsured

● A policy or contract providing any health care benefits under Medicare Part C or Part D

● An annuity issued by an organization that is only licensed to issue charitable gift annuities

● Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract

● Any policy of reinsurance unless an assumption certificate was issued

● Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

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

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

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

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members or residents:

You may also call the California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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Auxiliary aids and services, free of charge, are available to you. **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time.

Humana Inc. and its subsidiaries provide free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Polski (Polish) Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

Italiano (Italian) Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

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हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

հայերեն (Armenian): Զանգահարեք վերը նշված հեռախոսահամարով՝ անվճար լեզվական օգնության ծառայություններ ստանալու համար:

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

This notice is available at **www.humana.com/legal/multi-language-support**.

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