THE DENTAL CONCERN, INC.

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 The Dental Concern, Inc. 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 The Dental Concern, Inc

Bruce Broussard
President

Table of Contents

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 The Dental Concern, Inc.

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 the 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 this 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, Your 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 and the Insured is responsible for any extras.

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. Employment; whether caused by, related to, or as a condition of employment, including self-employment, unless You are eligible for benefits under Workers' Compensation act 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.

“Benefit Reserve” means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

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 covered in full or in part as shown in the Schedule of Benefits.

"Claim Determination Period" means a consecutive benefit year. However it does not include any part of a consecutive year during which a person has no coverage under This Plan, or any part of a consecutive 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; (3) the Plan of the parent not having custody of the child; and finally, (4) the plan of the spouse of the noncustodial parent.. 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. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

(1) A secondary plan shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses.

(a) The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary and any savings shall be:
1. Recorded as a benefit reserve for the covered person; and
2. Used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period.

(b) By the end of the claim determination period, the secondary plan shall:
1. Determine whether a benefit reserve has been recorded for the covered person;
2. Determine whether there are any unpaid allowable expenses for that claims determination period; and
3. Pay any unpaid allowable expenses for that claim determination period.

(c) The secondary plan shall use the covered person's recorded benefit reserve, if any, to pay up to 100 percent of total allowable expenses incurred during the claim determination period, at the end of which:
1. The benefit reserve shall return to zero; and
2. A new benefit reserve shall be created for each new claim determination period.

(2) The benefits of the secondary plan shall be reduced when the sum of the benefits payable under the secondary plan, in the absence of this coordination of benefits provision, and the benefits that would be payable under the other plans, in the absence of a coordination of benefits provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period, with a reduction of benefits as follows:

(a) The benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses; and

(b) Each benefit is reduced in proportion and charged against any applicable benefit limit of the plan.

(3) If a person is covered by more than one secondary plan, the order of benefit determination requirements of this administrative regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the requirements of this administrative regulation, has its benefits determined before those of that secondary plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. The Dental Concern, Inc has the right to decide which facts are needed. The Dental Concern, Inc may get needed facts from, or give them to, any other organization or person. The Dental Concern, Inc need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give The Dental Concern, Inc 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, The Dental Concern, Inc 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. The Dental Concern, Inc 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 The Dental Concern, Inc 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 VIII-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.

SECTION IX – INTERNAL APPEAL AND EXTERNAL REVIEW PROCESS

A covered person, an authorized person, or a provider acting on behalf of the covered person may request an internal appeal of a UR decision made by or on behalf of the covered person with respect to the denial, reduction, or termination of a limited health service plan or the denial of payment for a health care service. Refer to the Internal Appeal Process procedures below on how to initial an internal appeal.

To request an expedited (oral) or non-expedited (written) appeal send your request to:

The Dental Concern, Inc.
Attn: Quality Manager
P.O. Box 14729
Lexington, KY 40512-4729
(877) 603-5516 ext. 4960

INTERNAL APPEAL PROCESS
The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person.

The covered person, the authorized person, or the provider acting on behalf of the covered person will be given at least 60 days from receipt of notice of an adverse determination or a coverage denial in which to file a request for an internal appeal.

The insurer will provide a decision to the covered person, authorized person, and provider on internal appeals of adverse determinations or coverage denials within 30 days after receipt of the request for an internal appeal.

The insurer or their designee shall render a decision not later than 3 business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized, or in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following: (1) placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of a bodily organ or part.

Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. In the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty areas to conduct the internal appeal.

Those portions of the medical records that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers will be given the opportunity to present additional information.

In addition to any previous notice and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the coverage person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include: (1) a statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available; (2) the state of licensure, medical license number, and the title of the person making the decision; (3) except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and (4) instructions for initiating an external review of an adverse determination, or filing a request for review with the office if a coverage denial is upheld by the insurer on internal appeal.

On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the office shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the office regarding the request for review within 5 days of receipt of notice to the insurer. Within 5 days of receiving the notice of the request for review from the office, the insurer shall provide to the office the following information:
(1) confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied; (2) confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process; and (3) the reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

Upon receipt of the information described above, unless the office is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the office determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review, where the conditions precedent to the review are present. If the office notifies the insurer that the treatment, service, drug or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

An insurer shall be required to cover the treatment, service, drug or device that was denied or provide notification of the right to external review whether the covered person has disenrolled or remains enrolled with the insurer.

If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed 30 days, or provide the covered person the opportunity for external review.

EXTERNAL REVIEW PROCESS
A covered person, an authorized person, or a provider acting on behalf of the covered person and with consent of the covered person may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

The insurer shall provide for an external review of an adverse determination if the following criteria are met: (1) the insurer, its designee, or agent has rendered an adverse determination; (2) the covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification. The insurer and the covered person may however, jointly agree to waive the internal appeal requirement; (3) the covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and (4) the entire course of treatment of service will cost the covered person at least $100 if the covered person had no insurance.

The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within 60 days of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

The covered person shall be assessed a one time filing fee of $25 to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

A covered person shall not be afforded an external review of an adverse determination if: (1) the subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and (2) no relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

The office shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the office shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two consecutive external reviews. The office shall contract with not less than two independent review entities.

If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the office. Within 5 days of receipt of the complaint, the office shall rendered a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds: (1) the dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and (2) all of the requirements for filing an external review, have been met.

The external review process shall be confidential and shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized or if in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following: (1) placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of a bodily organ or part.

Requests for expedited external review shall be forwarded by the insurer to the independent review entity within 24 hours of receipt by the insurer.

For expedited external review, a determination shall be made by the independent review entity within 24 hours from the receipt of all information required from the insurer. An extension of up to 24 hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication that the adverse determination has been assigned to an independent review entity for expedited review.

External reviews which are not expedited shall be conducted by the independent review entity and a determination made within 21 calendar days from receipt of all information require from the insurer. An extension of up to 14 calendar days may be allowed if the covered person and the insurer are in agreement.

As used in these procedures the following definitions apply:

Adverse determination means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are: (1) not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and (2) benefit coverage is therefore denied, reduced, or terminated. Adverse determination does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan.

Concurrent review means utilization review (UR) conducted during a covered person's course of treatment or hospital stay.

Coverage denial means an insurer's determination that a service, treatment, drug or device is specifically limited or excluded under the covered person's health benefit plan.

External review means a review that is conducted by an independent review entity.

Independent review entity means an individual or organization certified by the office to perform external reviews.

Internal appeals process means a formal process, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent.

Private review agent or agent means a person or entity performing UR that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. Private review agent or agent does not include an independent review entity which performs external review of adverse determinations.

Prospective review means UR that is conducted prior to a hospital admission or a course of treatment.

Retrospective review means UR that is conducted after health care services have been provided to a covered person. Retrospective review does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment.

Urgent care means health care or treatment with respect to which the application of the time periods for making non-urgent determinations: (1) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (2) 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 care or treatment that is the subject of the UR. Urgent care includes all requests for hospitalization and outpatient surgery.

Utilization review (UR) means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review.

Utilization review (UR) plan means a description of the procedures governing UR activities performed by an insurer or a private review agent

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.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

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

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 **(TTY: 711)**... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك **(TTY: 711)**.

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