2023 Summary of Benefits

Siffrin, Inc.

Humana®

SLC00002016

Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
  Humana Privacy Office
  P.O. Box 1438
  Louisville, KY 40202

what's inside...

Throughout this booklet, you'll find lots of information to help you choose and use your plan:

- know what you need
  take a few minutes to find out what kind of healthcare coverage you want and need. thinking about how you'll use your plan is the first step in choosing with confidence.

- explore your options
  after finding out about your needs, it's time to see what fits them. the plan information in this section explains what's available to you, why you might want it, and how it works.

- see all that Humana offers Also
  included in this booklet are the resources and information that will show you all the ways that Humana is there for you in every aspect of your life.

- choose and use your plan
  now you're ready to roll – or enroll!

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have a look...

Humana Dental PPO 14

OHIO

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	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,000 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	100% after deductible		80% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years limited to crowns, bridges, and dentures. Coverage limited to equivalent cost of a non-implant service. Implant placement itself is not covered)	60% after deductible		50% after deductible	

Orthodontia services

Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the maximum allowable charge of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Employer-sponsored funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	Not available
Late applicant [1, 2]	No	12 months	12 months	Not available

[1] Late applicants not allowed with open enrollment option.
[2] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

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Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit Humana.com.

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental's PPO plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered servcies by choosing dentists in the HumanaDental PPO Network. To find a dentist in HumanaDental's PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page gives you a summary of HumanaDental benefits. Your plan certificate describes your HumanaDental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at **HumanaDental.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

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Humana Dental Traditional Preferred 14

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Healthy smiles lead to healthy lives

Good oral health is essential for well-being

A healthy smile starts with good oral hygiene. Brushing, flossing and seeing the dentist regularly help teeth and gums look and feel better. But that's just the start.

The mouth can be a window to the body. Medical researchers discover more connections between good oral health and good general health every year. Poor oral health has been linked to a variety of general health problems, such as heart disease and strokes.

More than 47% of Americans suffer from periodontal disease[1]

Dental insurance makes good oral health easy and affordable

As a health and wellness company, we recognize the strong connection between good overall health and good oral health. That's why **Humana dental plans** make dental care more accessible and affordable for you.

Choose your dentist from our nationwide network of more than 252,000 dentist locations. Plus, you'll enjoy our network discount, which can help you save on preventive and treatment services.

Get preventive care to keep little problems from becoming big issues. Humana dental benefits include 100 percent coverage for two routine cleanings each year plus other preventive care including exams, X-rays, space maintainers for children and oral cancer screenings with no deductible. You even have the benefit of four periodontal cleanings each year. Check with your employer for coverage details.*

Oral infections are linked to:
16% increase in heart disease
9% increase in diabetes[3]

Humana dental plan advantages:

- **Online access to MyHumana.com**, your personal, secure online account on **Humana.com**, where you can review dental plan benefits, manage claims and get information and education.
- **Free, personalized report**. Go to MyHumana.com to access My Dental IQ for a quick online quiz that gives you an assessment of your dental health plus important tips to stay healthy.
- **Easy-to-understand explanation of benefits** after every claim. Humana's SmartEOB℠ shows who was paid and includes personal messaging on how you can improve your oral health.
- **On-the-go mobile access to your Humana dental benefits.** Our plans are mobile-friendly to make it easy for you to view your digital ID cards, find dentists or manage claims through your smartphone.

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*Not available with Preventive Plus

[1] CDC, Prevalence of Periodontitis in Adults in the United States: 2009 and 2010, 09/12

[2] www.nytimes.com/health/guides/disease/periodontitis/risk-factors.html

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Dental insurance facts

How to choose a plan that meets your needs

Enrolling in the dental benefits plan offered by your employer can be a wise decision

For less than the cost of a cup of coffee a day, you can get both preventive and treatment services when and where you need it. With an affordable premium and a network discount on services, you won't need to delay dental care for you or your family.

These are the types of dental benefit plans that may be available as part of your employee benefits package:

- An **HMO** (health maintenance organization) plan is a copay-based, network-only offering that requires selection of a primary care dentist. Each family member on the plan can choose his or her own dentist. Because each service has a copay, members have clear upfront costs. There are no yearly maximums, no deductibles and no waiting periods.
- A **PPO** (preferred provider organization) plan offers low deductible options for preventive, basic and major services. In-network dentists provide dental services at a reduced rate. Members have higher out-of-pocket costs for services received from out-of-network dentists.
- A **traditional preferred** plan offers low deductible options for preventive, basic and major services, and the flexibility to see any dentist. With this plan, members receive the same level of coinsurance with all dentists. However, when members choose dentists in the Humana Dental PPO network, they can benefit from our negotiated rates for services received from in-network dentists.
- A **Preventive Plus** plan covers commonly used basic and major services, including exams, X-rays, cleanings and fillings. Plus, discounts may be available on additional services like crowns, inlays, oral surgery and orthodontia.

ASK YOUR EMPLOYER ABOUT YOUR HUMANA DENTAL PLAN OPTIONS TODAY.

How an affordable premium can save you money

As an example, if your plan premiums cost $360*, dental insurance can save you money on both preventive and emergency care.

You may save as much as $277 with dental insurance*

Here's an example:

Preventive service	Average cost per visit	# of visits recommended each year	Annual cost
Preventive exam	$50.00	2	$100.00
Periodontic cleaning	$150.00	4	$600.00
Bitewing X-rays	$60.00	1	$ 60.00
Out-of-pocket costs **without** dental insurance			$760.00
Out-of-pocket costs **with** dental insurance[1]			$122.80
Your annual premium **with** dental insurance			$360.00
YOUR SAVINGS WITH DENTAL INSURANCE			**$277.20**

**Data rounded based on 50th percentile of Fairview Health data as of January 2014 for metropolitan Houston, Texas. Example is for illustration purposes only, and individual results may vary.*

The cost of repairing cracked or broken teeth or replacing missing teeth can add up quickly:

- The average cost of an **all-porcelain crown** is about $1,430 per tooth.[2]
- The average cost of a **single tooth implant** with an all-porcelain crown is about $4,250.[2]

Having dental insurance can help get the care you need when you need it, by reducing your out-of-pocket costs.

Humana dental plans are one more way we're closing the gap between you and care

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[1] Assumes routine exam and bitewing X-rays are covered at 100 percent. Periodontic cleanings incur a $50 deductible and plan pays 80 percent of network fees with 31 percent off usual charges. Network fees vary by geography and provider; members may experience negotiated fees greater than or less than 31 percent.

[2] www.dentalimplantcostguide.com/dental-crowns/

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Humana Vision 100

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Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$100 allowance 20% off balance over $100	$50 allowance
Standard plastic lenses[4]		
• Single vision	$25	Up to $25
• Bifocal	$25	Up to $40
• Trifocal	$25	Up to $60
• Lenticular	$25	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$25	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$100 allowance, 15% off balance over $100	$80 allowance
• Disposable	$100 allowance	$80 allowance
• Medically necessary	$0	$200 allowance

Humana Vision 100

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis [1].

[1] Thompson Media Inc.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

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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 identity, or religion. 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 **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (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.
1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 1018

Humana Basic Life

Siffrin

OHIO

Coverage	Loss	Benefit
Life insurance	Death	Your beneficiary will receive $30,000.
Accelerated death benefit [1]	Terminal illness with a life-expectancy of 24 months or less. You must have continuous coverage a minimum of six months in order to qualify.	50 percent of the life benefit amount to a maximum benefit of $250,000. The final life benefit amount will be reduced by the amount of the accelerated death benefit paid (may vary by state).
Accidental death or bodily injury (AD&D)	Death as the result of an accident.	Your beneficiary will receive $30,000.
	As the result of an accident, loss of: both hands or feet; sight of both eyes; one hand and one foot; one hand or one foot and sight of one eye; complete paralysis (quadriplegia)	You will receive $30,000.
	As the result of an accident, loss of: one hand; one foot; sight of one eye; loss of thumb and index finger of same hand; partial paralysis (paraplegia and hemiplegia)	50 percent of the life benefit amount.
AD&D includes the following benefits:		
Common carrier benefit	Death or dismemberment as a fare paying passenger	200 percent of life benefit amount
Seat belt-airbag-helmet benefit	Death as the result of an auto accident while properly using a seat belt, or wearing a properly fitted and fastened motorcycle helmet in a motorcycle accident.	Amount of your accidental death benefit increases by 10 percent, but not less than $1,000 or more than $10,000. In addition, we will increase your accidental death benefit by 5 percent, to a maximum of $5,000 but no less than $500, for a properly functioning airbag.
Education benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit. Payable up to four years for employee's dependent children or until age 25. Dependent must be a full-time student beyond 12th grade at a college, university or vocational school on the date of the employee's death or within 365 days after the death.
Childcare benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit. For a dependent in a licensed childcare center up to four consecutive years after the employee's death, or until the child's 13th birthday.

AD&D includes the following benefits:

Coma benefit	Employee is in a coma caused by a body injury, the coma begins within 365 days after the accident; and the person remains in a coma for more than 31 consecutive days	One time payment of 5 percent of the employee's benefit, subject to a maximum of $5,000.
Repatriation benefit	Death as the result of an accident.	Actual expenses to a maximum of $5,000 if employee dies as a result of an accidental death at least 150 miles from his/her principal place of resident, and there are expenses for preparing and transporting the employee's body to a mortuary.
Spouse training benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit for one year after the employee's death. Survivor must be enrolled as a student in an accredited school on the date of the employee's death or within 365 days after the death.

Coverage	Loss	Benefit
Dependent insurance	Death of spouse Death of dependent child*	No dependent coverage selected. No dependent coverage selected.

[1] Residents of Alabama, Illinois, Indiana, Massachusetts, Michigan, Ohio, Oklahoma, Virginia and Washington must have continuous coverage a minimum of 30 days to qualify for illness coverage. Residents of Texas must have continuous coverage a minimum of six months to qualify for illness coverage. For accidents, coverage begins on the effective date of the policy.

*Some limitations apply.

Age reduction schedule

Beginning at age 65 (or age 70 in schedule three), employee life coverage will reduce based on the benefit amount in force on the employee's 64th birthday (or age 69 in schedule three). Basic Dependent Spouse Life terminates at age 65.

Age	Schedule two
65	35 percent
70	50 percent

Rate guarantee

Rate is guaranteed not to change for one year from the effective date of the policy.

Eligibility to participate

Active, full-time employees are eligible for coverage.

Waiver of premium

If you are totally disabled for at least six consecutive months prior to age 60, you can continue life insurance coverage and waive the premium. Waiver ends at age 65.

Conversion privilege

If your employment ends, you may be eligible to convert your coverage to an individual whole life insurance policy.

How much life insurance do you need?

The real question is:

How much will your loved ones need for short- and long-term expenses?

According to the American Council of Life Insurers (ACLI), a guideline is a life insurance amount equal to 10 times your annual income. No rule applies to everyone, however, because financial situations and goals vary from person to person and family to family. Use our simple online life insurance calculator at HumanaLife.com to help determine your life insurance needs.

Questions?

Check out **HumanaLife.com**

Call 1-800-233-4013 anytime for automated information or 8 a.m. to 6 p.m. for a customer service representative.

Insured by Humana Insurance Company or Humana Insurance Company of Kentucky.

This is not a complete disclosure of plan qualifications and limitations. Please review your Certificate of Insurance for a complete list of benefits. The Certificate of Insurance is the document upon which eligibility and benefit payment will be determined. Your agent/broker will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage.

Humana®

Policy Number: GN-70050-07 EM POLICY 5/06 et.al.

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, marital status, or religion. 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 **1-877-320-1235** 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, **1-800-368-1019**, **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: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (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.

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Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
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Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
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GCHJV5REN 0220

Humana Voluntary Life

Siffrin

OHIO

Coverage	Loss	Benefit
Life insurance	Death	100 percent of the life benefit amount.
Accelerated death benefit [1]	Terminal illness with a life-expectancy of 24 months or less. You must have continuous coverage a minimum of six months in order to qualify.	50 percent of the life benefit amount to a maximum benefit of $250,000. The final life benefit amount will be reduced by the amount of the accelerated death benefit paid (may vary by state).
Accidental death or bodily injury (AD&D) [2]	Death as the result of an accident	100 percent of the life benefit amount.
	As the result of an accident, loss of: both hands or feet; sight of both eyes; one hand and one foot; one hand or one foot and sight of one eye; complete paralysis (quadriplegia)	100 percent of the life benefit amount.
	As the result of an accident, loss of: one hand; one foot; sight of one eye; loss of thumb and index finger of same hand; partial paralysis (paraplegia and hemiplegia)	50 percent of the life benefit amount.

AD&D includes the following benefits:

Common carrier benefit	Death or dismemberment as a fare paying passenger	200 percent of life benefit amount
Seat belt-airbag-helmet benefit	Death as the result of an auto accident while properly using a seat belt, or wearing a properly fitted and fastened motorcycle helmet in a motorcycle accident.	Amount of your accidental death benefit increases by 10 percent, but not less than $1,000 or more than $10,000. In addition, we will increase your accidental death benefit by 5 percent, to a maximum of $5,000 but no less than $500, for a properly functioning airbag.
Education benefit	Death as the result of an accident	Actual expense to a maximum of $5,000 or 5 percent of death benefit. Payable up to four years for employee's dependent children or until age 25. Dependent must be a full-time student beyond 12th grade at a college, university or vocational school on the date of the employee's death or within 365 days after the death.

AD&D includes the following benefits (Continued):

Childcare benefit	Death as the result of an accident	Actual expense to a maximum of $5,000 or 5 percent of death benefit. For a dependent in a licensed childcare center up to four consecutive years after the employee's death, or until the child's 13th birthday.
Coma benefit	Employee is in a coma caused by a body injury, the coma begins within 365 days after the accident; and the person remains in a coma for more than 31 consecutive days	One time payment of 5 percent of the employee's benefit, subject to a maximum of $5,000.
Repatriation benefit	Death as the result of an accident	Actual expenses to a maximum of $5,000 if employee dies as a result of an accidental death at least 150 miles from his/her principal place of resident, and there are expenses for preparing and transporting the employee's body to a mortuary.
Spouse training benefit	Death as the result of an accident	Actual expense to a maximum of $5,000 or 5 percent of death benefit for one year after the employee's death. Survivor must be enrolled as a student in an accredited school on the date of the employee's death or within 365 days after the death.
Coverage	**Loss**	**Benefit**
Portability [3]	Termination of employment	Continue coverage by paying premiums directly to Humana. Employee must exercise portability option within 31 days of termination.
Dependent insurance	Death of spouse Death of dependent child*	You will receive the coverage amount selected. $10,000

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[2] The total benefit for all losses resulting from the same accident will be limited to the one type of loss which provides the greatest benefit. This is in addition to the life benefit amount.
[3] Portability is state-specific and is not available in Minnesota.
*Some limitations apply.

Age reduction schedule

Beginning at age 65 (or age 70 in schedule three), employee life coverage will reduce based on the benefit amount in force on the employee's 64th birthday (or age 69 in schedule three). Spouse benefits reduce based on spouse's age.

Age	Schedule two
65	35 percent
70	50 percent

Rate guarantee

Rate is guaranteed not to change for one year from the effective date of the policy.

Eligibility to participate

Active, full-time employees are eligible for coverage.

Waiver of premium

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Conversion privilege

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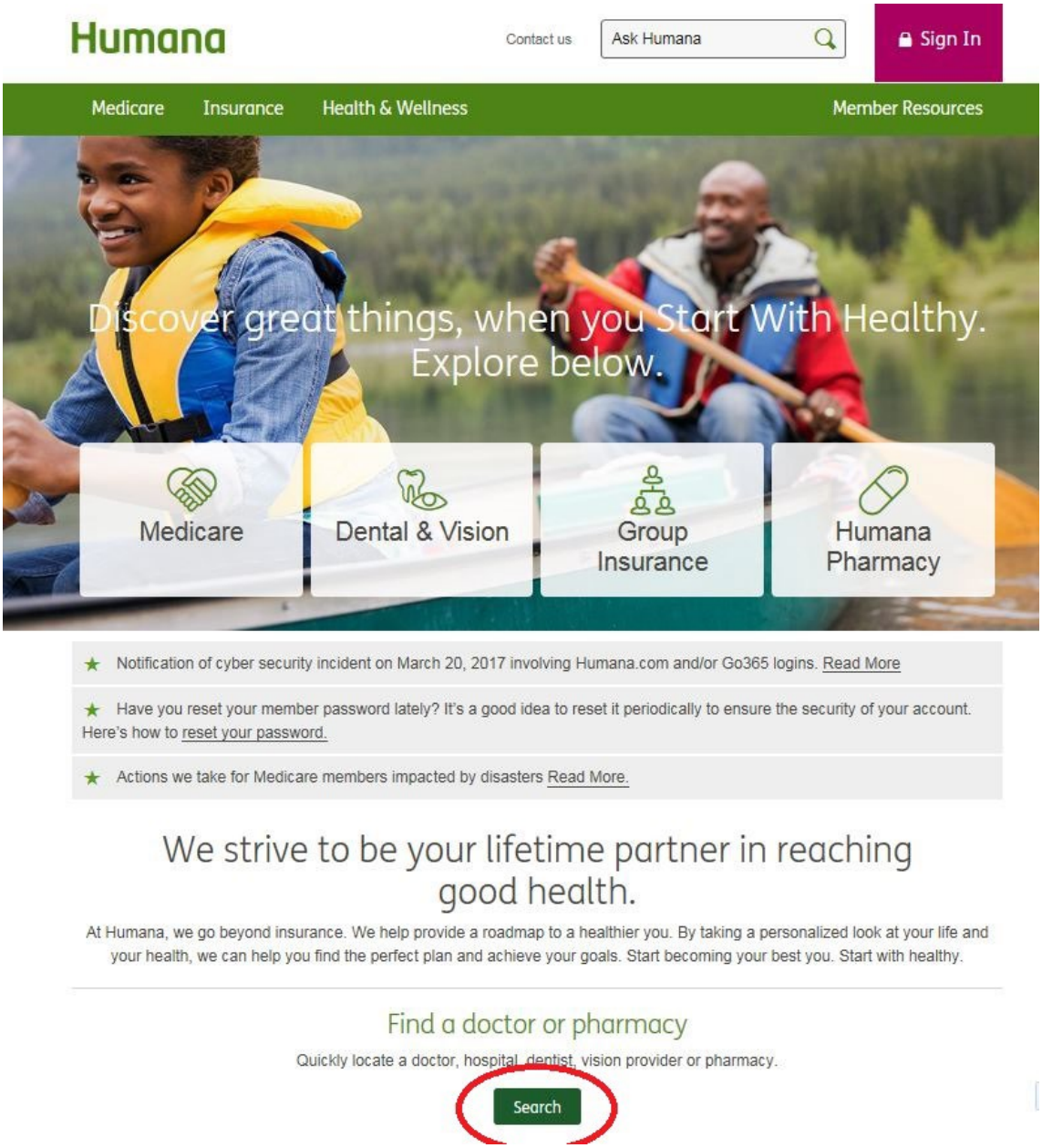
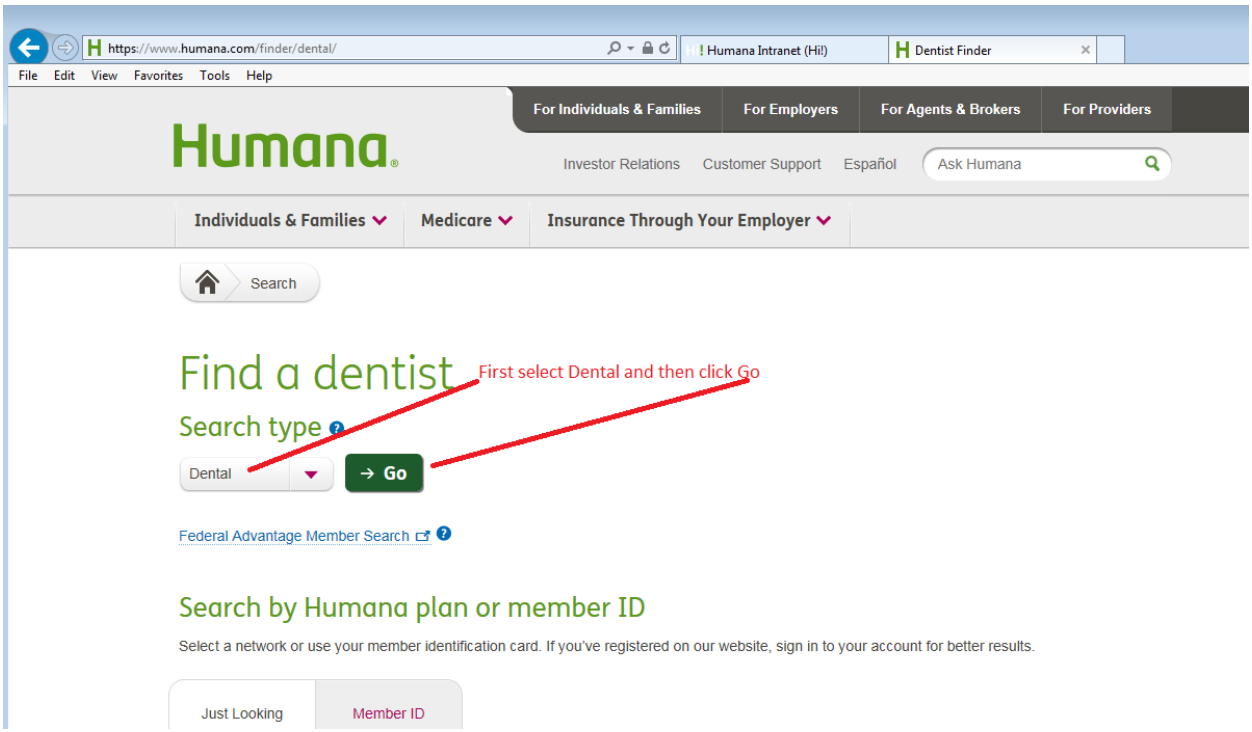
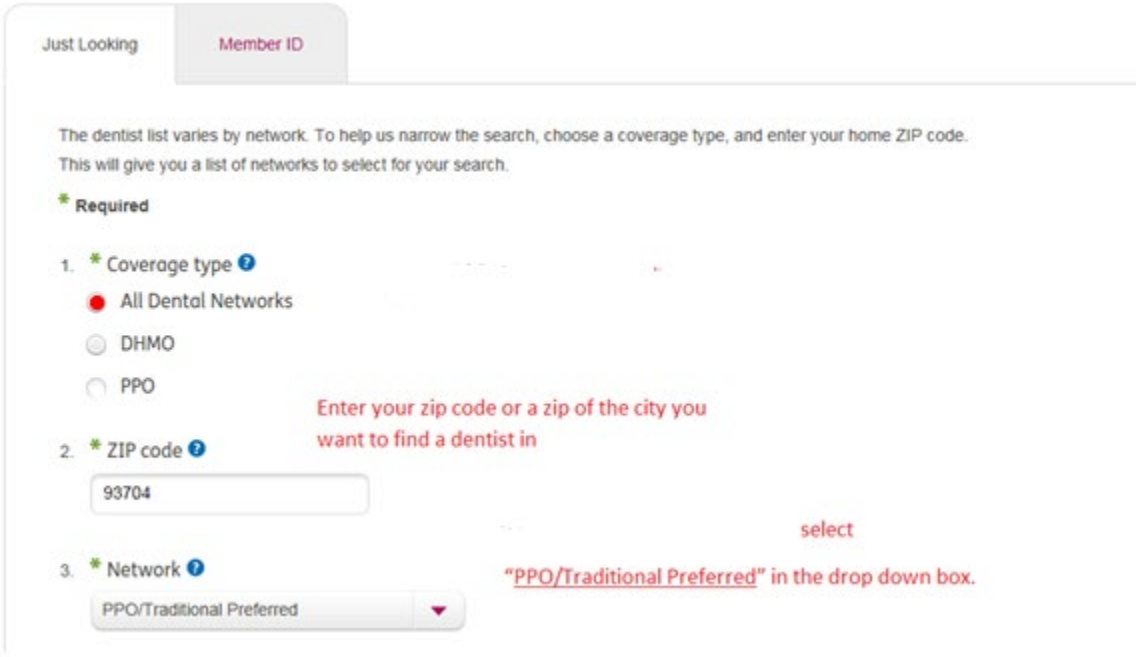
GCHJV5REN 0220

How to seach for a Dental provider

Start by going to www.Humana.com

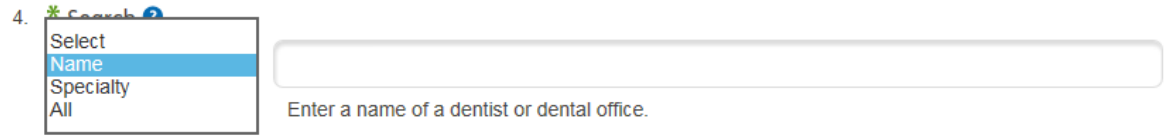



https://www.humana.com/finder/dental/
Humana Intranet (Hi!)
Dentist Finder
File Edit View Favorites Tools Help
For Individuals & Families
For Employers
For Agents & Brokers
For Providers
Humana.
Investor Relations
Customer Support
Español
Ask Humana
Individuals & Families
Medicare
Insurance Through Your Employer
Search
Find a dentist
First select Dental and then click Go
Search type
Dental
→ Go
Federal Advantage Member Search
Search by Humana plan or member ID
Select a network or use your member identification card. If you've registered on our website, sign in to your account for better results.
Just Looking
Member ID

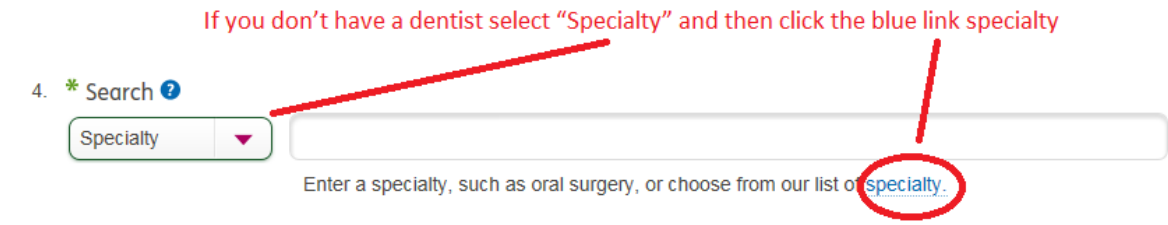

Just Looking
Member ID
The dentist list varies by network. To help us narrow the search, choose a coverage type, and enter your home ZIP code.
This will give you a list of networks to select for your search.
* Required
1. * Coverage type
All Dental Networks
DHMO
PPO
Enter your zip code or a zip of the city you want to find a dentist in
2. * ZIP code
93704
select
3. * Network
"PPO/Traditional Preferred" in the drop down box.
PPO/Traditional Preferred

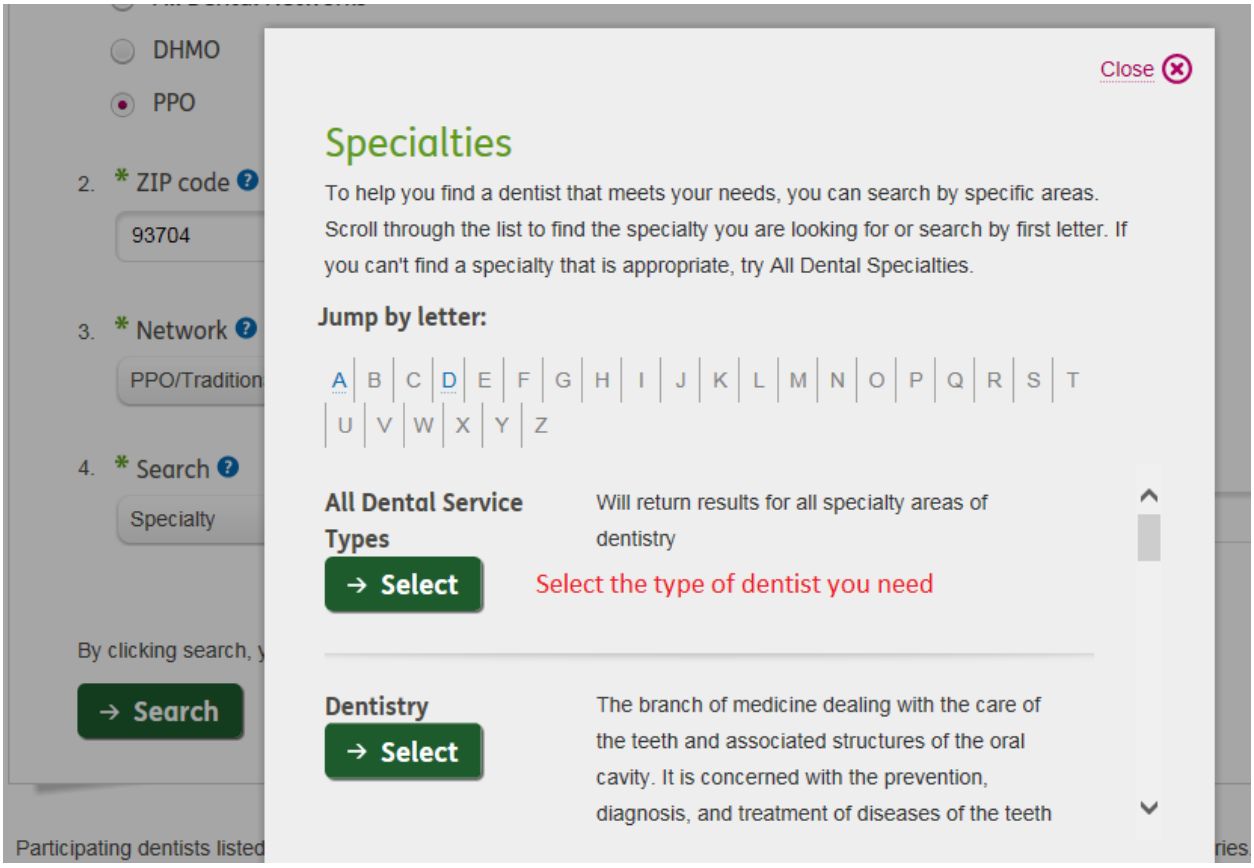
Next you have a few options on how to search for the dentist:

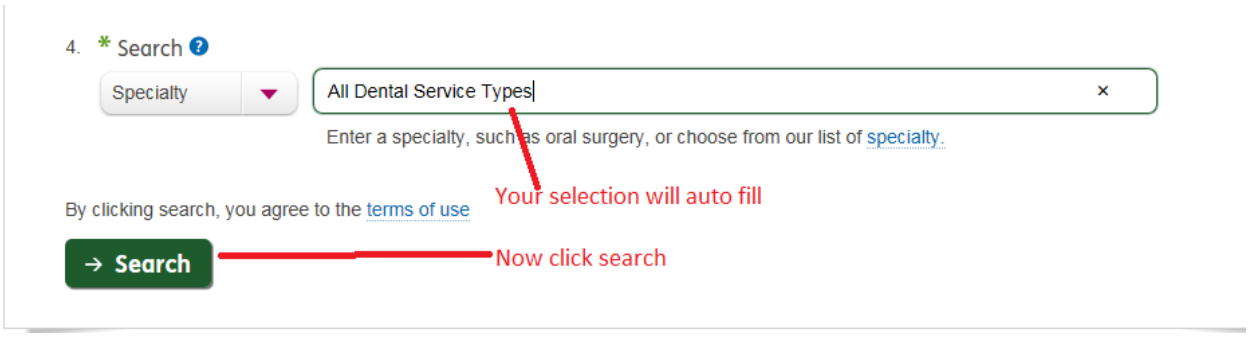
If you have a dentist you can search by name



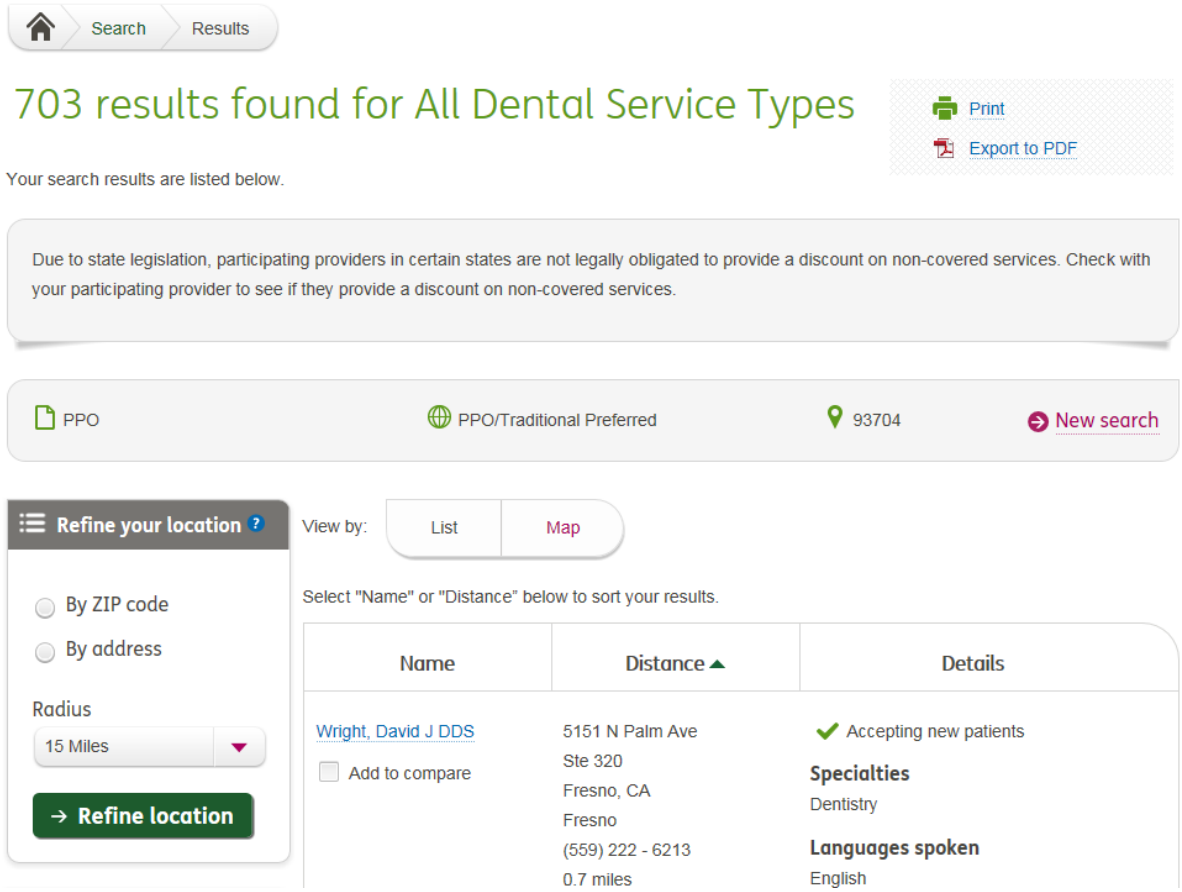
Otherwise you can search for all dentists in an area







And now you have your list of dentists

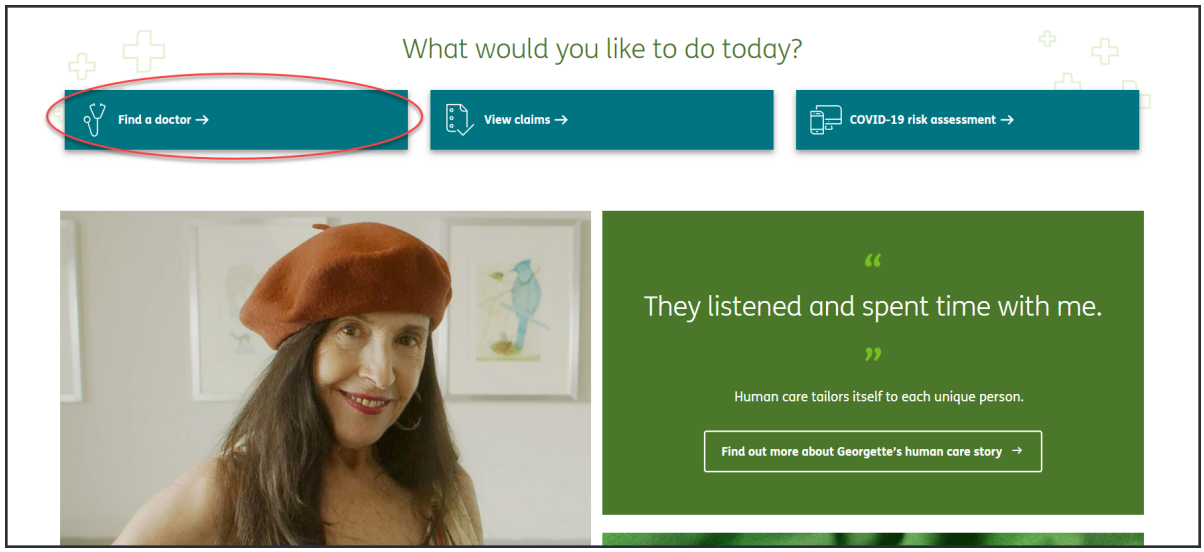


You can then refine your search by radius of search in miles, names of dentists, specialties and other sorting options. You can also save and/or print the provider list.

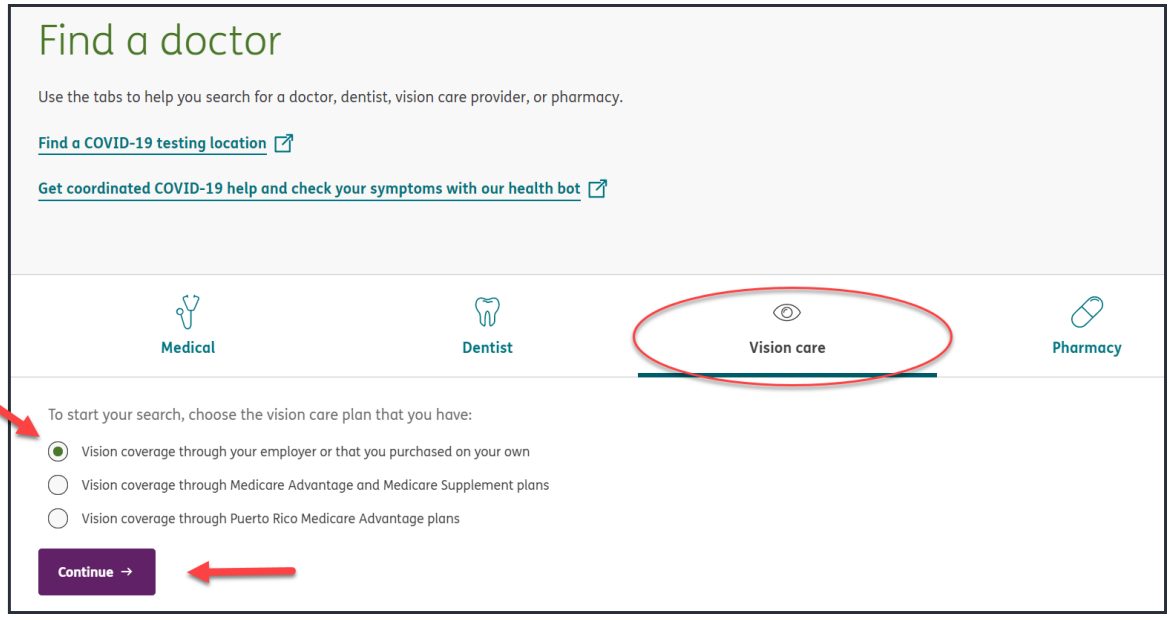
How To Find Your Vision Provider

Humana Insight Network

1. Go to www.humana.com
2. Scroll down the page and click on “Find a doctor"

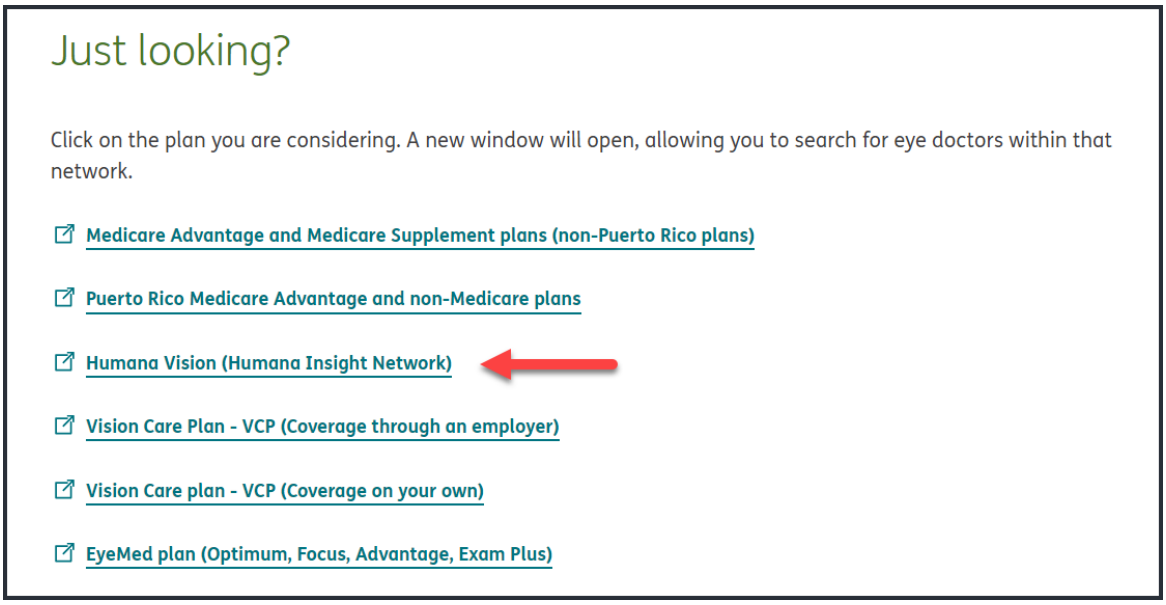


3. Click on the “Vision care” tab
4. Select “Vision coverage through your employer or that you purchased on your own”
5. Click “Continue”

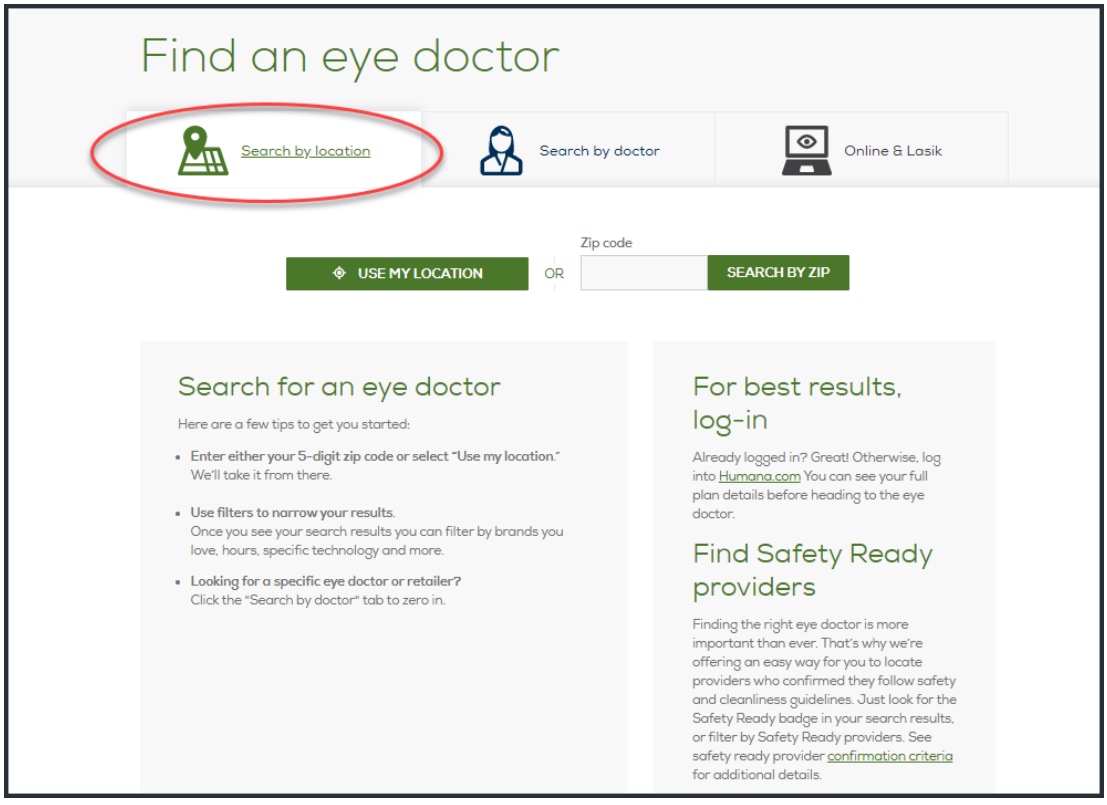


Humana.

6. Select “Humana Vision (Humana Insight Network)” from the list of options



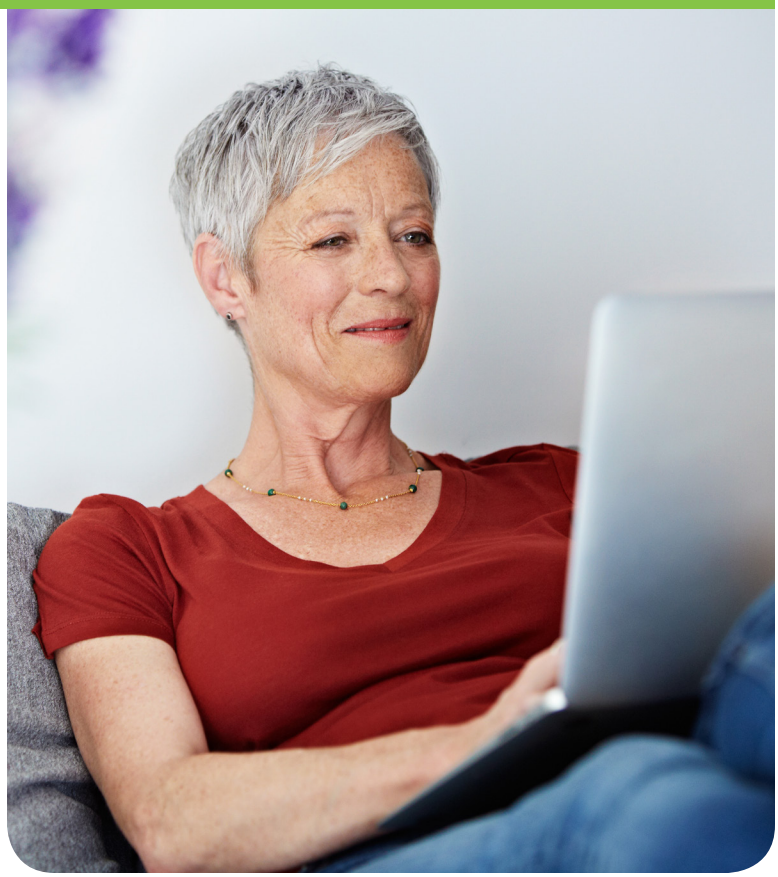
7. To search by location enter you 5-digit zip code or select "Use My Location"; follow the prompts on the next page to bring up providers in your area



MyHumana

Your secure member account

MyHumana is a secure and personalized account that lets you view your plan information online in one place, anytime you want.



With **MyHumana,** you can:

- View your plan details
- Choose how you want to get your plan information: online or in print
- See your latest claims, status and other details
- Find in-network providers, hospitals, pharmacies and urgent care centers
- Give a family member access to your health information
- Update your contact information

Registering is easy

- Have your Humana member ID or Social Security number available
- Go to **Humana.com/registration**
- Click "Get Started"
- Fill in some basic information and click "continue"
- Create a username, password and security prompt and click "continue" to finish

Register today!
Humana.com/**registration**

We go where you go!

Do you have a smartphone? Download the free **MyHumana** Mobile app!

Humana.com/**mobile**

Text and data rates may apply.

Humana®

MyHumana Mobile app

Access your health information anytime, anywhere

Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision and pharmacy claims
- View and fax medical, dental and pharmacy ID cards
- View your plans and coverage details
- View your HumanaVitality® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your Humana Pharmacy™ prescriptions

Download the Mobile App:

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play or App Store.

Download on the App Store

ANDROID APP ON Google play

From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or sign in (have your Humana ID or Social Security number available)
2. Click on the "Menu" icon
3. Select "Text Alerts"
4. Register and verify your mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or sign in (have your Humana ID or Social Security number available)
2. Click on "Account settings & preferences"
3. Select "Edit your preferences"
4. Select "Mobile" from the tab
5. Register and verify your mobile #
6. Select the alerts you want to receive

†Available to HumanaVitality members only.
*Message and data rates may apply.

Humana®

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

If you believe that **Humana Inc. and its subsidiaries** have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Large Group 51+ Employee Enrollment Form — OHIO

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group 51+ Employee Enrollment Form as "Humana".

- Humana Health Plan of Ohio, Inc., 1100 Employers Blvd, Green Bay, WI 54344
- Humana Insurance Company, 1100 Employers Blvd, Green Bay, WI 54344

HMO plans offered by Humana Health Plan of Ohio, Inc. POS plans offered by Humana Health Plan of Ohio, Inc. and insured or administered by Humana Insurance Company. PPO and Indemnity Medical plans, Dental, Life and Vision plans insured or administered by Humana Insurance Company.

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

Qualifying Event Instructions

❍ New business enrollment
❍ New hire/Newly eligible
❍ Dependent birth or adoption
❍ Loss of coverage
❍ Open Enrollment event
❍ Rehire/Reinstatement
❍ Marital status change
❍ Other_____

Office use only

Qualifying event date (MM/DD/YYYY) / /

Benefit effective date (MM/DD/YYYY) / /

Employee information

Last name

First name

MI

Social Security Number - -

Date of birth (MM/DD/YYYY) / /

Area code ( )

Phone number -

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male

Language of choice ❍ English ❍ Spanish

City

State

Zip code

County / Parish

E-mail address

Are you actively at work? ❍ Yes ❍ No If not, reason:

❍ Retiree ❍ COBRA Other: _____

Date of full-time hire (MM/DD/YYYY) / /

Do you have a disability that affects your ability to communicate or read? ❍ No ❍ Yes

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason:_____

Annual salary $

Hours worked per week

Occupation

HMO/POS only

Primary care physician name

Primary care physician ID #

Current patient? ❍ Yes ❍ No

HMO/POS only

OB/GYN Primary care physician name (if applicable)

Primary care physician ID #

Current patient? ❍ Yes ❍ No

Dependent information

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

---

4 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social Security Number ___ - ___ - ____ | Date of birth (MM/DD/YYYY) __ / __ / ____ | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student ❍ Disabled If disabled, indicate reason:_____

Not applicable for HumanaAccess HMO

HMO/POS only — Primary care physician name | Primary care physician ID # | Current patient? ❍ Yes ❍ No

HMO/POS only — OB/GYN Primary care physician name (if applicable) | Primary care physician ID # | Current patient? ❍ Yes ❍ No

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Street address

Apt / Suite / PO box number

City | State | Zip code | County

Medical

Coverage type:
- ❍ Employee / Individual only
- ❍ Employee / Individual & spouse
- ❍ Employee / Individual & child(ren)
- ❍ Family
- ❍ Other

Office use only
Group # | Benefit # | Class/Div #

Plan name | Network name

Do you or any covered dependent(s) currently have other medical coverage, such as a spouse's plan, another Humana medical plan, or Medicare? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medicare ID or medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Have you or any covered dependent(s) had medical insurance from a company (including another Humana plan) in the past 18 months? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any medical claims.)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Prior medical carrier name:

Starting date (MM/DD/YYYY) / /

End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply)
- ❍ Employee / Individual
- ❍ Spouse
- ❍ Child(ren)

Medical Health History (for 51-100 groups) - Do not submit more than 90 days prior to the effective date

1. Within the past 24 months have you or any dependent to be covered had or been treated for an illness or injury, had surgery or hospitalization recommended? ❍ N ❍ Y
2. Within the past 24 months have you or any dependent to be covered been prescribed medication? ❍ N ❍ Y
3. Have you or any dependent to be covered incurred medical expenses in excess of $7,500 in the past 12 months? ❍ N ❍ Y

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder OH-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments received

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) / /

Date last seen by a doctor (MM/DD/YYYY) / /

Health Savings Account (HSA) Applicable only with High Deductible Health Plan selection

Do you elect the Health Savings Account?
❍ Yes ❍ No If no, complete waiver section

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Office use only
Group # Benefit # Class/Div #

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Flexible Spending Account (FSA)

Do you elect the flexible health account?
❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA HC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Do you elect the flexible dependent health account? ❍ Yes ❍ No If no, complete waiver section

Annual amount elected:
$, .00

Office use only
Group # Benefit # Class/Div #
FSA DC

Start date (MM/DD/YYYY) / / End date (MM/DD/YYYY) / /

Dental

Coverage type:
❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ Employee / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # Benefit # Class/Div #

Plan name

Within the past 12 months, have you or any covered family individual had any dental or orthodontia coverage, such as a spouse's dental coverage? ❍ Yes ❍ No If yes, list all: (This section must be completed for Humana to process any dental claims)

Current dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage Type (check all that apply) ❍ Employee / Individual ❍ Spouse ❍ Child(ren)

Prior dental carrier name: Orthodontia coverage? ❍ Yes ❍ No Starting date (MM/DD/YYYY) / / End date, if applicable (MM/DD/YYYY) / /

Coverage type check all that apply)
❍ Employee / Individual only
❍ Employee / Individual and child(ren)
❍ Employee / Individual and spouse
❍ Family

	Employee primary care dentist name	Dentist ID #	Current patient?
DHMO			❍ Yes ❍ No
	Dependent primary care dentist name	Dentist ID #	Current patient?
1 DHMO			❍ Yes ❍ No
2 DHMO			❍ Yes ❍ No
3 DHMO			❍ Yes ❍ No

Basic Life / AD&D

Do you elect basic employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section

Office use only
Group # Benefit # Class/Div #

Class (employer / group will provide you with this information if needed)

Do you elect basic dependent life? ❍ Yes ❍ No If no, complete waiver section

Voluntary Life / AD&D

Do you elect voluntary employee / individual life coverage?
❍ Yes ❍ No If no, complete waiver section
If yes, amount elected (minimum of $15,000):
$, .00

Office use only
Group # Benefit # Class/Div #

Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):

Do you elect voluntary spouse life coverage? ❍ Yes ❍ No If no, complete waiver section
If yes, voluntary souse life coverage (minimum of $5,000): $, .00

Do you elect voluntary child(ren) life coverage? ❍ Yes ❍ No If no, complete waiver section

Vision

Coverage type:
❍ Employee / Individual only
❍ Employee / Individual & spouse
❍ Employee / Individual & child(ren)
❍ Family
❍ Other

Office use only
Group # Benefit # Class/Div #

Plan name

Beneficiary Information for Life

Primary beneficiary
Last name First name MI

Relationship to employee / individual

Secondary beneficiary
Last name First name MI

Relationship to employee / individual

Evidence of Health Status - Do not submit more than 90 days prior to the effective date

Complete this section if you are selecting ONLY Life over the guarantee issue amount.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y

Evidence of Health Status (continued)

2a. In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ N ❍ Y
2b. Is any applicant currently a smoker? If yes, applies to: ❍ You (employee) ❍ Dependent 1 ❍ Dependent 2 ❍ Dependent 3 ❍ Dependent 4	❍ N ❍ Y
3. In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
4. Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
5. Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:	

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y	i.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y	j.	Stomach, gall bladder, digestive, intestinal, or colon disorders?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y	k.	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y	l.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y	m.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
f.	Kidney stones; bladder?	❍ N ❍ Y	n.	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
g.	Male or female organs; or infertility?	❍ N ❍ Y	o.	Alcoholism or drug habit?	❍ N ❍ Y
h.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y			

6.	**Excluding HIV**, has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y
7.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y

Evidence of Health Status (continued)

	First Name	MI	Height (ft/in)	Weight (lbs)
❍ Employee last name			'	
❍ Dependent 1 last name			'	
❍ Dependent 2 last name			'	
❍ Dependent 3 last name			'	
❍ Dependent 4 last name			'	

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder OH-51340-MH), if necessary.

Question# | Person Treated Last name | First Name

Condition | Treatments received

Medications | Current or future treatments or medications

Date diagnosed (MM/DD/YYYY) / / | Date last seen by a doctor (MM/DD/YYYY) / /

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):

Medical for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Health Savings Account for:	❍ Myself		
Flexible Health Account for:	❍ Myself		
Flexible Dependent Care Account for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:_____

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Large Group 51+ Employee Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group 51+ Employee Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group 51+ Employee Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.

- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- In the event that an application is submitted outside of an open enrollment period, without a qualifying event, or by submitting an incomplete enrollment form Humana reserves the right to delay coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group 51+ Employee Enrollment Form.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group 51+ Employee Enrollment Form by Humana.

STATE NOTICE:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer or health maintenance organization, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice of Cancellation: If you are obligated for any part of a premium rate in connection with enrollment in this health plan, in addition to any right otherwise available to revoke an offer, you may cancel such agreement within 72 hours after having signed an enrollment form. Cancellation occurs when written notice of cancellation is mailed to Humana, its representatives or the employer (Ohio HMO and POS plans only). My designated representative or I have the right to receive a copy of this authorization at any time by writing to Humana's Privacy Office.

Authorization

My dependents and I understand and agree:
- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Large Group 51+ Employee Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life

If my dependents or I have selected life I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements. This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office. My designated representative or I have the right to receive a copy of this authorization at any time by writing to Humana's Privacy Office.

The Large Group 51+ Employee Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal representative signature _____ Date ☐☐/☐☐/☐☐☐☐

Name and relationship of legal representative (if a covered dependent) _____

Life Authorization Form

Humana®

Humana.com

		Group number
Employer name	City	State
Employee name	Date of birth	Social Security Number
Spouse name	Date of birth	Social Security Number

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy, pharmacy benefit manager, insurance, HMO, or reinsuring company, and the Medical Information Bureau, Inc., having information regarding myself, including information concerning, advice, diagnosis, treatment and care of the physical, mental or emotional conditions, drug, substance or alcohol abuse, illness (and copies of all hospital or medical records, non-public personal health information, and any other nonmedical information), and prescription drug history to share any and all such information with Humana, or its reinsurer, or its legal representatives, and its affiliates for purposes of business improvement and development.

I understand and agree:

- Although Humana is required to inform me that any health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules, any information obtained will not be released by Humana to any person or organization.
- A copy of this authorization is available to me or my legal representative upon written request.
- This authorization shall be valid for two years from the date shown below.
- You have the right to revoke this authorization at any time by sending written notice Humana's Privacy Office. The revocation will become effective after it is received by us but will not apply to information that has already been released in response to this authorization.

Employee signature	Date
Spouse signature	Date