Agent Product and Process Guide

› Supplemental Health and Life Insurance
› Stand-alone Dental and Vision Insurance
Welcome

Important contact information

Agent services:

› For agents primarily selling Medicare
  1-800-309-3163 or agentsupport@humana.com
  7 a.m. to 8 p.m. CDT, Monday – Friday

› For agents primarily selling HumanaOne medical products
  1-866-305-6318 or agentask@humana.com
  7 a.m. to 7 p.m. CDT, Monday – Thursday
  7 a.m. to 6 p.m. CDT, Friday

› Agent Workbench Online
  Application Assistance
  – Supplemental Health and Life Insurance:
    1-877-493-3207
  – Stand-alone Dental & Vision Insurance:
    1-888-675-7386
  – 7 a.m. to 7 p.m. CDT, Monday – Thursday
  – 7 a.m. to 6 p.m. CDT, Friday

› Questions related to active policies
  and policyholder materials
  – Supplemental Health and Life Insurance:
    1-800-833-6578
  – Stand-alone Dental & Vision Insurance:
    1-866-537-0232
  – 8 a.m. to 6 p.m. CDT, Monday – Friday

› Licensing and commission inquiries
  – HumanaOne agents: 1-800-558-4444, x 8919
    8 a.m. to 4:30 p.m. CDT, Monday – Friday
  – MarketPoint agents: 1-800-309-3163
    7 a.m. to 8 p.m. CDT, Monday – Friday

› Claims and customer service
  1-888-629-2669 (Supp. Health & Life)
  1-877-203-4249 (Dental & Vision)
  8 a.m. to 6 p.m. CDT, Monday – Friday

Claims and customer service for policyholders:

› Supplemental Health and Life Insurance
  1-877-207-0158
  8 a.m. to 6 p.m. CDT, Monday – Friday

› Stand-alone Dental & Vision Insurance
  1-888-629-2669
  8 a.m. to 6 p.m. CDT, Monday – Friday

Welcome to the Agent Product and Process Guide for individual supplemental health and life insurance, and stand-alone dental and vision plans from HumanaOne. This guide provides information to help you with quoting and submitting applications, as well as explaining the billing process to your client. This guide is for HumanaOne licensed agents. MarketPoint agent processes may be different in some instances. Please contact the Agent Service Unit for assistance if needed. Your success is important to us, and we are committed to offering you the products, services, and support that can help you surpass your goals.

Online resources:

HumanaOne Agent Workbench

The HumanaOne Agent Workbench (AWB) is a secured, powerful online tool. To access the AWB, you must be a registered user. Simply go to Humana.com/sellhumanaone and login. To register, go to Humana.com/sellhumanaone and click “Register” in the top navigation bar or in the left-hand navigation bar.

› Once you have registered:
  – Enter your User ID and Password in the left-hand navigation bar
  – Click on “HumanaOne Agent Workbench” in the bottom right of the page

› Information and tools that can be found on the HumanaOne AWB include:
  – Obtain and track quotes and applications (for applications started on AWB)
  – Product information, including what products are available by state
  – Marketing tools and sales support materials

› Tips:
  – AWB is only compatible with Windows-based systems (Internet Explorer and Firefox).
  – Disable all pop-up blockers when accessing AWB

Humana.com/sellhumanaone

Visit this agent web page for information about our products and services. Learn what products are available in your state and how HumanaOne’s broad portfolio of products can help grow your business. You can also view and print marketing materials to share with your clients. Inside the Agent Resource Center you can find the most up-to-date Product and Process Guides and Underwriting Guides. The login for the AWB and Ordering System can be found on this page.

Note: This guide is for agent use only, and the information is subject to change without notice. State-specific information is not provided but can be found on Humana.com/sellhumanaone. Policy information supersedes the information in this guide.

Please advise your client not to cancel any current supplemental health, or life insurance coverage until receipt of policy materials.

Applications are subject to approval. Waiting periods, limitations, and exclusions may apply.
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Obtaining quotes

HumanaOne offers several convenient ways to obtain a quote:

- **AWB online:** In the “Generate a new quote” box, select the plan and complete the online form. Once the online form is completed, click “Save”. You will have the option to email the quote to your client with a unique web link that the client can use to view the quote and apply online. (Please be sure to use your Humana Agent Number and not your Agency Number on the quote, this will allow Humana to credit commissions on the approved applications to you.)

- **Rate Sheets:** Available on AWB under Order Marketing Materials & Plan Summaries (in the bottom left hand section of the page)

- **Rate Calculator:** Download the rate calculator to quote products offline (the rate calculator should be updated regularly by uninstalling and reinstalling):
  http://www.cashcancerinsurance.com/humanaratescalculator/publish.htm

To quote HumanaOne products, you must be licensed, contracted/appointed, and trained to sell the product by Humana.

**Please note:** A medical appointment alone will not allow you to sell these products. Please contact your sales representative (local sales office for MarketPoint agents) or the Agent Service / Support Center to become appointed.
Submitting applications

Once you’ve confirmed HumanaOne meets your client’s needs, checked your client’s eligibility, and obtained a quote, choose one of the following options to complete the application process:

1. Agent online application

Using the unique web link generated when the online quote is completed, clients can apply online for HumanaOne Supplemental Health and Life Plans at their convenience. And, because this Web address is specific to you and your client, you will receive credit for the sale and the commission. Please note: The online application must be completed by the applicant and not by an agent. If an agent completes the application, it is no longer a valid application, and the applicant will have to complete a new application.

To complete the application process, follow the steps below:

1. Your client compiles and has ready the following information:
   - Selected plan and any options
   - Demographic information
   - Current coverage
   - Valid email address
   - Social Security number
   - Billing option—electronic form of payment is needed for premium
   - Other policy information, including names of prior and current carriers, effective dates, plan numbers, and termination dates

2. Your client accesses the agent online application one of two ways:
   - Click on the hyperlink in the emailed quote
   - Manually enter the Web address from a printed quote

3. Your client completes the application online in a few steps:
   - Create an account
   - Select the product
   - Provide applicant details
   - Complete the health history
   - Select payment method
   - E-sign the documents

4. Once the application is completed, it’s forwarded to New Business Area for review. You’ll receive an email notifying you when the application is submitted. The New Business Area may be able to make a decision right away, or an underwriter may contact your client for more information or may request your client meet additional requirements. Your client also may be required to complete documents such as a Home Office Endorsement (HOE) or state-required forms. Your client will be notified by email if required to electronically sign the additional documents.
2. Agent-initiated application

The agent-initiated application on the AWB allows you to complete the application questions – but not the signature – with a client. Once completed, the application must be emailed to your client for an electronic signature. **You may not complete the agent-initiated application without your client.** Underwriting must have complete and accurate responses to all health risk assessment questions. In addition, complete banking information is necessary to proceed with the application. **You may not sign the application for your client under any circumstance.**

Follow these steps to complete an agent-initiated application:

- After a quote has been generated and saved, select “Apply” for the plan for which you wish to complete an application
- Create an online account for your client
- Complete the application with your client
- When it’s complete, email it to your client for electronic signing

Please ensure the application contains correct information before emailing as your client will not be able to make changes to the application.

3. Paper applications

Stand-alone supplemental health and life insurance paper applications and combined packets that include state-mandated forms are available for most states on Humana.com/sellhumanaone. Fax the completed paper applications to **1-877-720-4863**.

If a check (money orders not accepted) is included, please submit the applications and applicable forms to:

Kanawha Insurance Company  
Attn: HFPP New Business  
PO Box 7777  
Lancaster, SC 29271

**For MarketPoint Delegated Agents:**

- Fax applications to: 1-800-589-9309
- Mail to:  
  Humana Delegated Operations  
  5401 Kennedy Blvd – 4th Floor  
  Tampa, FL 33069

Application resolution

Most applications, that do not require additional underwriting requirements, are approved or declined by Humana’s Underwriting department within 10 days. Applications that require medical records or additional information can remain in process for 45 days.
Standard or approved coverage

Coverage is considered “standard” or “approved as applied for” after the application process is completed, payment information is received, and the applicant and all dependents applying meet Humana’s underwriting requirements. If an application is approved “standard” and signed by the applicant, the coverage will be issued.

Counteroffers

Underwriting can choose to counteroffer coverage to the proposed insured rather than decline coverage, based on medical history and the plan. Depending on the health status of the proposed insured, the coverage selected (i.e. deductible) could favorably impact your client’s eligibility. When counteroffers are made, an adverse underwriting letter will be sent to the applicant who must sign a Home Office Endorsement (HOE).

Declinations

Underwriting can decline to insure the applicant and/or any person applying for coverage if he or she does not meet the underwriting guidelines and/or requirements.

Changes in health

If you or the client becomes aware of a client’s change in health that occurs after the enrollment / application form date, but before coverage becomes effective, you or the client must report the change to Humana’s Underwriting department by calling 1-800-825-7858.
Changes to in-force business

The following changes require a Post-sale form to be completed:

<table>
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<tr>
<th>Change</th>
<th>Action</th>
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<tr>
<td>Addition of a dependent child</td>
<td>If the coverage type allows, the policy owner can apply to add dependents. They must complete an application as follows:</td>
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<tr>
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<td>• Check the change to existing coverage box at the top of the application</td>
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<td>• Write in the current policy number at the top of the application to which the dependent(s) are to be added</td>
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<td>• List the dependent(s) requesting coverage on page 1</td>
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<td>• Complete questions on page 2</td>
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<td>• The policy owner and agent signs and dates the application</td>
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<td></td>
<td>• Submit the additional premium</td>
</tr>
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<td></td>
<td>• Submit the completed application for the additional dependent.</td>
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<tr>
<td></td>
<td>Coverage is only effective if approved by Humana</td>
</tr>
</tbody>
</table>

| Addition of a spouse                        | If the coverage type allows, the policy owner can apply to add a spouse. They must complete an application as follows: |
|                                            | • Check the change to existing coverage box at the top of the application |
|                                            | • Write in the current policy number at the top of the application to which the spouse is to be added |
|                                            | • List the spouse requesting coverage on page 1                        |
|                                            | • Complete questions on page 2                                        |
|                                            | • The policy owner and agent signs and dates the application          |
|                                            | • Submit the additional premium                                       |
|                                            | • Submit the completed application for the spouse.                    |
|                                            | Coverage is only effective if approved by Humana                       |

| Addition of a newborn / newly adopted child | Varies by state and if the plan type allows. Please reference the policyholder’s policy or call a customer care specialist at 1-877-207-0158. |

| Conversion as a result of death            | The policy owner must send notification to Humana to remove the covered person due to death |
|                                            | The service department will send notification to the policyholder to advise of conversion rights and instructions for applying for conversion policy |

| Conversion as a result of divorce          | The policy owner must send notification to Humana to remove the spouse coverage due to divorce |
|                                            | The service department will send notification to spouse to advise of conversion rights and instructions for applying for conversion coverage and make the appropriate change to the original policy |

To request changes to an issued policy, policy owners and/or agent can:

- Contact Customer Service at 1-877-207-0158. The applicant will receive the required forms to be completed by mail.
- These forms are also available to agents on the Humana AWB under Order Marketing Materials & Plan Summaries (in the bottom left hand section of the page). Select Life and Supplemental Health Insurance, the state the policy is issued in, and the product. Forms are located under Post-sale Materials.

Provide the form to the policy owner to be completed and mailed:

Kanawha Insurance Company; Attn: HFPP Policy Services; P.O. Box 7200; Lancaster, SC 29721
Billing options

The policy owner or an alternate may be selected as the payor. However, an employer may not be named as a payor, and the payor and depositor/account holder must be the same.

Agents are not permitted to pay premiums other than for policies on themselves or for insureds where there is an insurable interest.

Bank draft

On the electronic application, a payer can choose the day of the month for the bank account to be drafted (1-28 only; 29-31 not available). If no debit date is selected, recurring bank drafts will occur every payment period on the day that corresponds to either:

- The effective date of the policy if that date is pre-selected
- The date the policy is issued if an effective date is not pre-selected

For example: Client signs the application on June 2, does not want future effective date, and does not select a debit date

- Effective date will be June 2
- Application issues on June 5
- Initial payment will be taken on June 5
- Subsequent payments will be taken on the day that corresponds to the effective date, which is the 2nd day of the month if monthly payment mode is selected

Client will not receive a bill each month. Each bank draft debit should be considered proper notice of the premium being due.

Credit / debit card*

Credit/debit cards are charged:

- On the effective date of the policy if that date is pre-selected
- On the date the policy is issued if an effective date is not pre-selected

Recurring payments will be charged every payment period based on the payment mode chosen and will occur on the day that corresponds to the effective date of the policy.

* Additional fees may apply. May not be available for all plans.
Agent licensing and appointment requirements

All agents who solicit insurance business on behalf of Humana (and all companies affiliated with Humana), as well as any agent or agency that will receive commissions from Humana, are required to complete a Group Producing Agent/Agency Contract.

All agents/agencies soliciting insurance business are required to hold an active agent/agency license in every state in which they solicit business. Along with establishing licensing requirements for agents/agencies, states require agents/agencies to be appointed by Humana in each state in which business is solicited.

Individual products from Humana require that the agent/agency be non-resident licensed if they are soliciting business for prospective clients in states other than their resident state. An agent/agency appointment with Humana cannot be processed without an active agent license. Both the writing agent and agent of record must be licensed, contracted, and appointed.

If you have any agent licensing or appointment questions, please contact your HumanaOne sales representative or call the Agent Service / Support Center.

Commissions, referrals, and incentives

Please refer to the Producer Partnership Plan for commission structure information.
Tools and services to help you grow your business

Agent communications

You will be kept up-to-date on HumanaOne product news, marketing and sales tools and events in your area by email. Please ensure your email address is current by logging into AWB, and clicking on the “My Information” tab in the upper right hand corner of the main page.

Marketing materials and guidelines

Pre-approved agent marketing materials

HumanaOne provides professional-quality advertising pieces that you may customize with your name, agency, and phone number. These materials can help increase the name recognition of your agency, increase sales of HumanaOne products, and drive real results to your bottom line.

Contact your sales representative for details or to request advertising materials.

General guidelines for advertising in the Yellow Pages

Yellow Pages advertising must be placed under the name of the agent or agency, not Humana, and the agent or agency must be listed as an authorized agent for HumanaOne. The HumanaOne logo must appear on the display ad, but cannot be altered in any way. All advertising materials must have prior approval from Humana. To obtain approval for an agent-produced ad, please submit it, along with how it will be used, to H1SharedMarketing@Humana.com. Please allow three weeks for approvals.

Faxing guidelines

The Telephone Consumer Protection Act (TCPA) of 1991 prohibits marketers, including agents, from sending faxes to individuals with whom they have no existing business relationship. In the event of a violation of the TCPA, individuals are entitled to collect damages directly from the marketer for $500 to $1,500, or recover actual monetary loss, whichever is higher. Agents in violation of the Act also can have their Humana contract terminated.
Overview of products and underwriting guidelines

The information provided over the next several pages is intended to provide a high-level overview of our products. In addition, underwriting guidelines have been included for each product to make the process as easy as possible.

To find out which life and supplemental health plans are available from HumanaOne in your state, visit Humana.com/sellhumanaone.

For the most up-to-date information on product features and benefits, as well as state-specific dependent information and definitions, visit Humana.com/sellhumanaone and refer to the plan summary.

Cash Cancer Plan

*No one plans to get cancer. Help your clients be prepared if it happens to them.*

- Proactive solution to lessen the financial impact to family
- Multiple plan options with benefit amounts of $10,000, $20,000, $25,000, $30,000, $40,000 or $50,000 *
- Cash paid directly to insured or their designee
- Provides one-time cash payment upon the first diagnosis of internal cancer or malignant melanoma (skin cancer other than malignant melanoma is not covered)
- No treatment required to receive benefits, only a diagnosis
- Same coverage available to all family members, regardless of age*
- No medical exams required, only a few health questions

* May vary by state
• Return of Premium (ROP) rider can be added at time of purchase, if the insured was 18-64 years old when the policy was issued, and the insured’s policy remains continuously in-force for 20 years without a claim, the premiums will be returned to the insured/owner.* If the primary insured was 65-69 years old when the policy was issued, and the insured’s policy remains continuously in-force for 10 years without a claim, 50% of the premiums will be returned to the insured/owner.
• 20-year pay option can be added, which means that if the insured pays their premiums for 20 years with no lapse in coverage and no claims paid or incurred, the insured may keep their policy for life (or until terminated based on a claim payment) without any additional premiums due
• 30-day money-back guarantee

Health underwriting guidelines

The following circumstances will result in a person not being eligible for coverage:
• Question 1 on the application is answered “YES”
• Health history that includes one of the ineligible conditions

The following information only provides your client’s potential eligibility; it is not a final determination. Our underwriting department upon receipt of an application makes all final coverage decisions. This assessment is not an offer of coverage or notice of declination for your client.

Eligibility / issue ages:
• 18 – 69 for primary and 18 – 74 for spouse
• 0 – 17* for dependents:
  – Children must apply with a parent; child only coverage is not available
  – Dependent children must be less than 18 years of age and unmarried, or less than 26 if a full-time student
  – Disabled children can continue coverage past attained age
• Applicants must be a U.S. Citizen or have a U.S. Permanent Resident Card (green card) and have lived in the U.S. for a minimum of one year

Effective dates:
• Date of application. Policy effective dates must be between 1st and 28th of the month
• Future date will not be allowed
• Backdating is not allowed

Waiting period, limitations, and exclusions:
30-day waiting period from the policy effective date before coverage begins. In addition, there is a 24-month pre-existing condition limitation provision and exclusions. (May vary by state.)

* May vary by state
Tobacco usage:

- The rates are Tobacco / Non-tobacco. If any applicant is a tobacco user; the rates are Tobacco rates
- Humana has two tobacco classes:
  - Tobacco user
  - Non-user: Does not use ANY form of tobacco currently or has not used ANY tobacco product in the last 12 months

Existing Humana / Kanawha coverage:

The total amount of Cash Cancer coverage in-force with Humana / Kanawha or any carrier cannot exceed $100,000.

- If any previous coverage exists with Humana / Kanawha, the application will be sent to underwriting for review when the application is submitted.

Underwriting requirements:

- The application is a simplified application. If all health questions are answered “no” the application will be issued provided all signatures are in place and the applicant(s) answered the health questions truthfully.
- Truthfully means that the client has answered questions to the best of their knowledge and there are no answers on previous applications or other documentation that contradict the answers given on the current application. If this occurs, the underwriter will conduct a phone interview with the applicant to verify the current health status.

Ineligible condition list:

- AIDS/AIDS Related Complex (ARC), HIV
- Cancer - Internal
- Hodgkin’s Disease
- Leukemia
- Malignant Growth
- Melanoma

This is a guide only. It is not intended to be a complete listing and is subject to change without notification. If you are unsure whether your client is eligible for coverage, contact the agent services by calling 1-877-203-4249 before submitting an application.
Critical Illness Plan

*Think of it as the safety net your clients need in case the unexpected occurs.*

- Provides a lump sum payment for a covered critical illness*
- Benefit amounts of $5,000 to $50,000* with lump sum benefits for all covered family members**
- Return of Premium (ROP) rider can be added at time of purchase, which means if the insured's policy remains continuously in-force for 20-year increments without a claim, the premiums will be returned to the insured/owner.*
  Premiums will continue to be returned to the insured / owner every 20 years if the insured's policy remains continuously in-force without a claim.
- 30-day money-back guarantee

Health underwriting guidelines:

The following circumstances will result in a person not being eligible for coverage:

- Question 1, 2, or 3 on the application is answered "YES"
- Health history that includes one of the ineligible conditions
- Height / weight that exceeds the limits identified in the build chart

The following information only provides your client's potential eligibility; it is not a final determination. Our underwriting department upon receipt of an application makes all final coverage decisions. This assessment is not an offer of coverage or notice of declination for your client.

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* May vary by state
** Children may only be eligible for 20% of the benefit of the primary insured. Benefit amounts may reduce by 50% at age 70.
Eligibility / issue ages:

- 18 – 69* for primary and spouse
- 0 – 17* for dependents
  - Children must apply with a parent; child only coverage is not available
  - Dependent children must be less than 18 years of age and unmarried, or less than 26 if a full-time student
  - Disabled children can continue coverage past attained age
- Applicants must be a U.S. Citizen or have a U.S. Permanent Resident Card (green card) and lived in the U.S. for a minimum of one year

Effective dates:

- Date of application or date medical records are received by Humana, whichever is later
- Future date will not be allowed
- Backdating is not allowed

Waiting period, limitations, and exclusions:

- 30-day waiting period from the policy effective date before coverage begins. In addition, there is a 12-month pre-existing condition limitation provision and exclusions. (May vary by state.)

Tobacco usage:

- The rates are Tobacco / Non-tobacco. If any applicant has used tobacco in the last 12 months, the rates are tobacco rates. In Florida, an applicant is considered a tobacco user if they have EVER used tobacco, but applicants are rated separately (Ex: If the primary applicant is a tobacco user and the spouse is a non-tobacco user, the primary applicant receives tobacco rates and the spouse non-tobacco rates)
- Humana has two tobacco classes:
  - Tobacco user
  - Non-user: Does not use ANY form of tobacco currently or has not used ANY tobacco product in the last 12 months.

Existing Humana / Kanawha coverage:

- The total amount of Critical Illness coverage in-force with Humana / Kanawha cannot exceed $100,000
- The total amount of cancer coverage in-force with Humana / Kanawha cannot exceed $100,000
- If any previous coverage exists with Humana / Kanawha, the application will be sent to underwriting for review when it is submitted

Underwriting requirements:

- MIB for all ages
- Rx screen for all ages
- Review of current or previous Humana coverage including claim history check
- Medical records (APS) will be required on all applicants age 60 and over and at underwriter's discretion
  - The applicant's signature will be required to authorize the release of medical records
  - Humana will contact the vendor or doctor to arrange and pay for the APS
  - We encourage you to have the applicant reach out to the specific facility to expedite the processing of the request

Build chart:

* May vary by state
** Children may only be eligible for 20% of the benefit of the primary insured. Benefit amounts may reduce by 50% at age 70.
### Height / Weight Table

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<th>Inches</th>
<th>Maximum weight</th>
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<tr>
<td></td>
<td>≥ 8</td>
<td></td>
<td>344</td>
</tr>
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</table>

### Ineligible condition list:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cancer</th>
<th>Vascular</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/AIDS Related Complex (ARC), HIV</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Alcoholism, or alcohol, drug or substance abuse</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Angina (heart related chest pain)</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Angioplasty</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Cancer - Internal</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer - Skin</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Cerebral Vascular Disease (stroke, TIA, mini-stroke)</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Chronic Lung Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Currently confined to a hospital, nursing home or</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>other facility, or confinement recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes - Insulin Dependent</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Diabetes - Type II</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Digestive System disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Critical Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Disease or disorder leading to permanent or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>progressive loss of vision or speech</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Bypass</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Defect - Uncorrected</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Surgery</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Heart Valve Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hemiplegia, paraplegia, quadriplegia</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hepatitis, other than A</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hodgkin’s disease</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalized or treated outpatient in the past 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>months (excluding minor injuries and normal</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension/Elevated Blood Pressure</td>
<td>if not controlled with medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness/disability making it unable to perform</td>
<td>if in last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>normal duties at work, home, school or missed more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>than 5 consecutive days of work/school due to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>illness/injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Disease or Disorder (excluding Hepatitis A)</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Lung Disease or Disorder</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td>x</td>
<td></td>
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<tr>
<td>Malignant Growth/Tumors</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Melanoma</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Nervous System Disease</td>
<td>x</td>
<td>x</td>
<td></td>
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<tr>
<td>Parkinson’s</td>
<td>x</td>
<td>x</td>
<td></td>
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<tr>
<td>Peripheral Vascular Disease</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Receiving Hospice, Home Health Care, or Bedridden</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Stent</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Transient Ischemic Attack (TIA)</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

This is a guide only. It is not intended to be a complete listing and is subject to change without notification. If you are unsure that your client is eligible for coverage, contact the agent services by calling 1-877-203-4249 before submitting an application.
Hospital Cash Plan

*Make sure your clients are prepared for unplanned hospital costs.*

- Choice of benefit amounts up to $2,000 for hospital confinement
- Cash benefits paid directly to the policy owner or their designee for hospital confinement, outpatient surgery, and emergency accident or sickness
- Pays in addition to current health insurance (no coordination of benefits)
- 30-day money-back guarantee

**Health underwriting guidelines:**

The following circumstances will result in a person not being eligible for coverage:

- Question 1, 2, 3 or 4 on the application is answered “YES”.
- Health history that includes one of the ineligible conditions
- Height/weight that exceeds the limits identified in the build chart

The following information only provides your client’s potential eligibility; it is not a final determination. Our underwriting department upon receipt of an application makes all final coverage decisions. This assessment is not an offer of coverage or notice of declination for your client.

**Eligibility / issue ages:**

- 18 – 69* for primary and spouse (gender rated)
- 0 – 17* for dependents
  - Children must apply with a parent; child only coverage is not available
  - Dependent children must be less than 18 years of age and unmarried, or less than 26 if a full-time student
  - Disabled children can continue coverage past attained age
- Guaranteed renewable to age 70*
- Applicants must be a U.S. Citizen or have a U.S. Permanent Resident Card (green card) and have lived in the U.S. for a minimum of one year.

* May vary by state
Effective dates:

- Date of application. Policy effective dates must be kept between 1st and 28th of the month
- Future date is not allowed
- Backdating is not allowed

Waiting period, limitations, and exclusions:

- Cancer, hernia(s), adenoids and appendix or tonsils removal – 6 month waiting period unless treated on an emergency basis*
- Pregnancy and child birth – 10 month waiting period*
- No benefits are provided or paid under this policy for care or treatment of any covered person donating an organ during the first 12 months from the effective date of policy*
- There is a 12-month pre-existing condition limitation provision and exclusions. (May vary by state.)

Tobacco usage:

- No tobacco rating

Existing Humana / Kanawha coverage:

- The total amount of Hospital Cash Plan (Indemnity) coverage in-force with Humana / Kanawha cannot exceed $2,000 lump sum benefit
- If any previous coverage exists with Humana / Kanawha, the application will be sent to underwriting for review

Underwriting requirements:

- The application is a simplified application. If all health questions are answered “no” the application will be issued provided all signatures are in place and the applicant(s) answered the health questions truthfully.
- Truthfully means that the client has answered questions to the best of their knowledge and there are no answers on previous applications or other documentation that contradict the answers given on the current application. If this occurs, the underwriter will conduct a phone interview with the applicant to verify the current health status.

* May vary by state

May affect ability to contribute to Health Savings Account (HSA). Client should contact their tax advisor for determination.
Build chart:

### Height / Weight Table

<table>
<thead>
<tr>
<th>Height</th>
<th>Feet</th>
<th>Inches</th>
<th>Maximum weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
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<tr>
<td></td>
<td>11</td>
<td>196</td>
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<table>
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<th>Inches</th>
<th>Maximum weight</th>
</tr>
</thead>
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<td>334</td>
<td></td>
</tr>
<tr>
<td>≥ 8</td>
<td>8</td>
<td>344</td>
<td></td>
</tr>
</tbody>
</table>

### Ineligible condition list:

- AIDS/AIDS Related Complex (ARC), HIV
- Alzheimer's Disease
- Cancer (except for basal cell cancer) – diagnosed or treated in the past 5 years.
- Current or recommended confinement to a hospital, nursing home or other medical facility.
- Diabetes – Insulin dependent
- Liver disease or disorder (excluding hepatitis A)
- Kidney disease (excluding kidney stones)
- Surgery recommended that has not yet occurred.
- Systemic lupus
- Senile Dementia
- Uncorrected congenital heart defect (excluding mitral valve prolapse)
Ineligible condition list (continued):

- Within the past two years hospitalized or seen in emergency room for:
  - Angina (heart related chest pain)
  - Angioplasty
  - Asthma
  - Cerebral vascular accident (CVA)
  - Cerebral Vascular insufficiency
  - Chronic lung disease
  - Congestive heart failure
  - Crohn's Disease
  - Diabetes Type II
  - Emphysema
  - Heart attack
  - Heart surgery
  - Hypertension
  - Parkinson's Disease
  - Peripheral vascular disease (circulatory problems)
  - Sickle cell anemia
  - Stent placement
  - Stroke
  - Transient ischemia attack (TIA) or ministroke
  - Transplants
  - Ulcerative colitis
  - Uncorrected congenital heart defect (excluding mitral valve prolapse)

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Junior Estate Builder

Help your clients build a secure financial foundation for their child or grandchild.

- Affordable way to start planning for a child's or grandchild's future today
- Coverage is available at $15,000 and $20,000 with term life insurance now and the foundation of a whole life policy later
- Automatically converts to a whole life policy at age 25 with a one-time premium increase which generates a cash value that grows over time
- Benefit amount guaranteed not to decrease once the policy is purchased
- 30-day money-back guarantee
- Premiums payable only on an annual basis

Health underwriting guidelines:
A "Yes" answer to question 1a, 1b or 2 on the application will require additional underwriting review.

The following information only provides your client's potential eligibility; it is not a final determination. Our underwriting department upon receipt of an application makes all final coverage decisions. This assessment is not an offer of coverage or notice of declination for your client.

Eligibility / issue ages:
- Issue age 0 – 24
- Age is based on nearest birthday
- Initial term coverage is to age 25
- Applicants must be a U.S. Citizen or have a U.S. Permanent Resident Card (green card) and have lived in the U.S. for a minimum of one year

Effective dates:
- Date of application – policy effective dates must be kept between 1st and 28th of the month
Waiting period, limitations, and exclusions:

- No waiting period
- 2-year suicide exclusion

Tobacco usage:

- No tobacco rating

Existing Humana / Kanawha coverage:

- The total amount of Junior Estate Builder coverage in-force with Humana / Kanawha cannot exceed $50,000
- If any previous coverage exists with Humana / Kanawha, the application will be sent to underwriting for review

Underwriting requirements:

- The application is a simplified application. If all health questions are answered “no” the application will be issued provided all signatures are in place and the applicant(s) answered the health questions truthfully.
- Truthfully means that there are no questions on previous applications or other documentation that contradict the answers given on the current application. If this occurs, the underwriter will conduct a phone interview with the applicant to verify the current health status.

Ineligible condition list:

- AIDS/AIDS Related Complex (ARC), HIV
- Anemia (except for iron deficiency anemia)
- Asthma (if hospitalized within the 6 months prior to application or requiring multiple hospitalizations)
- Cancer
- Cerebral Palsy under age 22
- Cystic Fibrosis
- Diabetes
- Down's Syndrome
- Drug abuse
- Heart abnormalities
- Hepatitis C
- Hydrocephalus
- Hypoglycemia
- Kidney Disease
- Leukemia
- Lupus
- Seizures (more than 3 a year)
- Suicide attempt

This is a guide only. It is not intended to be a complete listing and is subject to change without notification. If you are unsure that your client is eligible for coverage, contact the agent services by calling 1-877-203-4249 before submitting an application.
Memorial Fund

You can relax, knowing your final wishes will be respected.

- Offers individuals a chance for a paid up insurance policy, with a premium option that pays the policy for 10 years
- Coverage amounts available in $1,000 increments up to $25,000
- Whole life insurance coverage that has guaranteed cash value
- Premium is guaranteed never to change for life and the benefit cannot be reduced
- Offers a graded death benefit with level premiums for prospects with health issues*

Health underwriting guidelines:
The following circumstances will result in a person not being eligible for coverage:

- If any question is answered “YES” in section A on the application
- Health history that includes one of the ineligible conditions

The following information only provides your client’s potential eligibility; it is not a final determination. Our underwriting department upon receipt of an application makes all final coverage decisions. This assessment is not an offer of coverage or notice of declination for your client.

**Eligibility / issue ages:**

- 45 – 80*
- Age is based on nearest birthday
- Applicants need to be a U.S. Citizen or have a U.S. Permanent Resident Card (green card) and have lived in the U.S. for a minimum of one year

**Effective dates:**

- Date of application – policy effective dates must be kept between 1st and 28th of the month

* May vary by state
• Future effective date allowed for a maximum of 45 days from date of application

**Waiting period, limitations, and exclusions:**

• No waiting period
• 2-year suicide exclusion
• Exclusions apply for AD&D under the Graded Benefit option

**Tobacco usage:**

• No tobacco rating

**Existing Humana / Kanawha coverage:**

• The total amount of Memorial Fund coverage in-force with Humana / Kanawha cannot exceed $25,000
• If any previous coverage exists with Humana / Kanawha, the application will be sent to underwriting for review

**Underwriting requirements:**

• The application is a simplified application. If all health questions are answered “no” the application will be issued provided all signatures are in place and the applicant(s) answered the health questions truthfully.
• Truthfully means that the client has answered questions to the best of their knowledge and there are no answers on previous applications or other documentation that contradict the answers given on the current application. If this occurs, the underwriter will conduct a phone interview with the applicant to verify the current health status.

**Ineligible condition list:**

• AIDS/AIDS Related Complex (ARC), HIV
• Alzheimer’s
• Cancer - diagnosed or treated within the past 12 months
• Dementia
• Melanoma – diagnosed or treated within the past 12 months
• Terminal Illness – terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.
• Currently receiving hospice or home health care or has been recommended to receive hospice or home health care.
• Currently bedridden, confined to a hospital, nursing home, or other facility, or has been recommended hospitalization, nursing home confinement or surgery, that has not yet occurred

This is a guide only. It is not intended to be a complete listing and is subject to change without notification. If you are unsure that your client is eligible for coverage, contact the agent services by calling 1-877-203-4249 before submitting an application.
Individual dental insurance

**Preventive Plus dental plan:**
Our Preventive Plus plan encourages preventive treatment, which helps keep your clients’ mouths healthy while minimizing their costs. And, because Humana has one of the largest PPO dental networks, with over 130,000 dentist locations, they’re sure to find a dentist they know and trust who practices near their home or work. Policy owner can see any dentist they choose, but can save when they visit dentist locations in HumanaDental’s nationwide PPO network.

**Preventive Plus plan features:**
- Many preventive services covered at 100%
- Many commonly used basic services are covered at 50% (after deductible)
- Substantial discounts on other basic and major services when using network providers
- Savings up to 30% by choosing network dentist

**Annual deductible:**
- $50 individual
- $150 family

**Annual maximum benefit:**
- $1,000 per member, per calendar year

**Plan administration:**
- Applications received and completed from the first through the last day of the month will be effective the first of the following month
- Premium will be drawn immediately upon issuance of the policy (can be before the effective date). Recurring monthly bank draft and credit card payment will be drafted on the 15th of the month.
- This plan requires a one-time, non-refundable enrollment fee and a 12-month commitment. This plan also requires monthly membership to an Association in some states.

*See your state-specific benefit summary for additional details.*
Prepaid HI215 dental plan:
With the Prepaid HI215 dental plan, your clients choose a primary-care dentist. There are no yearly maximums, deductibles, or waiting periods. Your clients do not submit claims because copayments, including an office visit copayment, apply at each visit.

- Preventive services—no copayment ($15 office visit charge may apply)
- Basic and major services—copayments apply (charges vary by procedure)
- Orthodontia discount—up to a 25% discount if visiting a participating orthodontist
- 25% discount on specialty services performed by participating specialists

Plan administration:
- Applications received and completed from the first through the 14th of the month will be effective the first of the following month. Applications received the 15th through the end of the month will be effective the first of the subsequent month (Ex: Application received on the 15th of July will be effective September 1.)
- Premium will be drawn immediately upon issuance of the policy (can be before the effective date). Recurring monthly bank draft and credit card payment will be drafted on the 15th of the month.

See your state-specific benefit summary for additional details.

Prepaid C550 dental plan:
With the Prepaid C550 dental plan, your clients choose a primary-care dentist. There are no yearly maximums, deductibles, or waiting periods. Your clients do not submit claims because copayments, including an office visit copayment, apply at each visit.

- Preventive services—no copayment ($10 office visit charge may apply)
- Basic and major services—copayments apply (charges vary by procedure)
- Orthodontia discount—up to a 25% discount if they visit a participating orthodontist
- 25% discount on specialty services performed by participating specialists

Plan administration:
- Applications received and completed from the first through the 14th of the month will be effective the first of the following month. Applications received the 15th through the end of the month will be effective the first of the subsequent month (Ex: Application received on the 15th of July will be effective September 1.)
- Premium will be drawn immediately upon issuance of the policy (can be before the effective date). Recurring monthly bank draft and credit card payment will be drafted on the 15th of the month.
Stand-alone Dental and Vision Plans

See your state-specific benefit summary for additional details.

Individual vision insurance

Vision Care Plan:

Plan features:
- Comprehensive vision exam once every 12 months
- Guaranteed approval – your clients will never be turned away for pre-existing conditions
- Wholesale frame allowance lets policyholders avoid high retail markups and pay the same no matter which network doctor they choose, once every 24 months
- Eyeglass lenses covered at 100 percent after $25 copay, once every 12 months
- Allowance for elective contact lens services and materials, once every 12 months
- 100 percent coverage on contact lens services and materials, if medically necessary
- Large network of more than 35,000 participating optometrist, ophthalmologist, and national retail locations, including LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney Optical
- Valuable discounts on laser vision correction procedures

Plan administration:
- Applications received and completed from the first through the last day of the month will be effective the first of the following month.
- Premium will be drawn immediately upon issuance of the policy (can be before the effective date). Recurring monthly bank draft and credit card payment will be drafted on the 15th of the month.

See your state-specific benefit summary for additional details.

Vision Focus Plan:

Plan features:
- Comprehensive vision exam once every 12 months
- Guaranteed approval – your clients will never be turned away for pre-existing conditions
- $100 allowance, plus additional discounts on retail frames, once every 24 months
- Eyeglass lenses covered at 100 percent after $25 copay, once every 12 months
- Allowance for elective contact lens services and materials, once every 12 months
- 100 percent coverage on contact lens materials, if medically necessary
- Large network of more than 35,000 participating optometrist, ophthalmologist, and national retail locations, including LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney Optical
- Valuable discounts on laser vision correction procedures

Customer care for claims:
- Dental claims: 1-866-537-0232
- Vision claims: 1-800-865-3676
Plan administration:

- Applications received and completed from the first through the last day of the month will be effective the first of the following month.
- Premium will be drawn immediately upon issuance of the policy (can be before the effective date). Recurring monthly bank draft and credit card payment will be drafted on the 15th of the month.

See your state-specific benefit summary for additional details.

Submitting applications for dental and vision plans

- Applications can be submitted online through AWB, through paper applications found on the AWB, or through your unique agent link that can be provided to the individual.
- For vision plans, applications received and completed from the first through the last day of the month will be effective the first of the following month.

Stand-alone dental and vision cancellation limitation

Because of the one-year contract, cancellation is limited to the following conditions:

For our stand-alone Dental plans:

- Prepaid Hi215 plan: Your clients may only cancel within 10 days of their effective date
- Prepaid C550 plan: Your clients may only cancel within 30 days of their effective date
- Preventive Plus plan: Your clients may only cancel within 10 days of their effective date (except New Hampshire, which is 30 days from effective date)

For our stand-alone Vision plans:

- Vision Care and Vision Focus plans: Your clients may only cancel within 10 days from their effective date

If your client cancels their membership within the above allotted cancellation period, they will be refunded their premium (not the enrollment fee). Your client will also be responsible for the full cost of any services received during this time period. The enrollment fee is non-refundable in all situations. You will not receive commission on any plans cancelled within the cancellation period. Association membership will automatically be cancelled.
This brochure is intended to provide a high level overview of HumanaOne plans and benefits. It is not intended to provide detailed information on state-specific benefits, limitations or exclusions. Product availability, options, benefits, and riders vary by state. Plans may not be approved in all states.

Applications may be subject to approval. Waiting periods, limitations and exclusions may apply. Please contact your Humana agent for a state-specific plan summary for additional information.

Dental and Vision Plans

Memorial Fund
Underwritten by Kanawha Insurance Company. Policy Form 00800 1/88 and, if applicable, graded benefit policy Form 00020 3/90.

Junior Estate Builder

Hospital Cash Plan
Underwritten by Kanawha Insurance Company. Policy Form 90840 and if applicable, optional rider Form 90841. Benefits and riders offered with these plans are not intended to cover medical expenses.

Critical Illness Cash Plan
Critical Illness Cash Plan is a critical illness insurance policy underwritten by Kanawha Insurance Company. Policy Form 70620 and if applicable, optional rider Form 70622 or 70623. Benefits and riders offered with these plans are not intended to cover medical expenses.

Cash Cancer Plan
HumanaOne Cash Cancer Plan is a cancer insurance policy underwritten by Kanawha Insurance Company. Policy Form 70130 and, if applicable, optional rider policy Form 70140 or Form 70145. Benefits and riders offered with these plans are not intended to cover medical expenses.