Agent Product and Process Guide

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

Welcome to the Agent Product and Process Guide for life and supplemental health insurance, and stand-alone dental and vision plans from Humana. 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 licensed Humana agents. MarketPoint agent processes may be different in some instances. Please contact the Agent Support 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

Humana Agent Workbench

The Humana Agent Workbench (AWB) is a secured, powerful online tool. To access the AWB, you must be a registered user. Simply go to Humana.com and login. To register, go to Humana.com 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 “Humana Agent Workbench” in the bottom right of the page

• Information and tools that can be found on the Humana 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 compatible with these browsers:
    IE 8,9,10, 11
    Firefox 24, 27
    Safari 5.0.2, 5.1.7
    Google Chrome 30, 33
  – Disable all pop-up blockers when accessing AWB

Humana Agent Portal

(accessed by signing into Humana.com)

Visit this agent web page for information about our products and services. Learn what products are available in your state and how Humana’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.
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## Important contact information

**Agent Support Unit (ASU)**  
1-800-309-3163 or agentsupport@humana.com  
7 a.m. – 8 p.m., Central time, Monday – Friday

**Customer Service and Claims for Agents**  
1-877-203-4249 (Life & Supp)  
1-800-592-3005 (Dental & Vision)  
8 a.m. – 6 p.m., Central time, Monday – Friday

**Customer Service and Claims for policyholders**  
1-877-207-0158 (Life & Supp)  
1-866-537-0232 (Dental & Vision)  
8 a.m. – 6 p.m. Central time, Monday – Friday

**Humana’s Underwriting department**  
1-800-825-7858  
8 a.m. – 5:30 p.m., Central time, Monday – Friday

## Life and Supplemental Insurance

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Humana 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.) You will be asked to register your account during your initial visit.

- **Get a quote:** access the link on the Supplemental Insurance Coverage for Individuals for Humana website: Humana-one.com/supplemental-insurance. Please note that this link will not assign an agent to the policy like the personalized link below (that includes your SAN ID).

Agents may generate a quote through AWB or they may add the link below to their website (replacing the “x”s with their SAN ID). This will allow clients to generate a quote themselves. Humana.com/insurance-plan-quotes/AOALanding?SANID=xxxxxxxx

To quote Humana 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.
Once you've confirmed Humana 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 Humana Life and Supplemental Insurance 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.

- The owner of the application may reside in a state other than the state where the application is taken. The agent should enroll the member using the application version that is approved for the owner's state of residence.

To complete the application process, follow the steps below:

- **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

- **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

- **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

- **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 Life and Supplemental Insurance paper applications and combined packets that include state-mandated forms are available for most states on the Humana Agent Portal (accessed by signing into Humana.com). You may fax the completed paper applications to 1-877-720-4863.

If you do not fax in your application and would prefer to mail the application you may submit the applications and applicable forms to:

Kanawha Insurance Company  
Attn: HFPP New Business  
210 S. White  
Lancaster, SC 29270

**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.
Counter offers
Underwriting can choose to counteroffer coverage to the proposed insured rather than decline coverage, based on medical history and the plan. 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.

Power of Attorney
For our Underwritten Financial Protection Products: We do not accept or allow POA (power of attorney) for any of our products during the underwriting process.
The following changes require a Post-sale form to be completed

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| 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, 8 a.m. to 6 p.m., Central time, Monday – Friday. If the coverage type allows, the policy owner can apply to add dependents. 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 dependent(s) are to be added  
  • List the dependent(s) requesting coverage on page 1  
  • Complete questions on page 2  
  • The policy owner and agent signs and dates the application  
  • Submit the completed application for the additional dependent.  
  **Coverage is only effective if approved by Humana** |
| Addition of a spouse or a dependent child   | If the coverage type allows, the policy owner can apply to add a spouse and/or dependent(s). 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 and/or dependent(s) are to be added  
  • List the spouse and/or dependent(s) requesting coverage on page 1  
  • Complete questions on page 2  
  • The policy owner and agent signs and dates the application  
  • Submit the completed application for the spouse and/or dependent(s).  
  **Coverage is only effective if approved by Humana** |
| Conversion as a result of death             | The policy owner must send notification to Humana to remove the covered person due to death  
  **Kanawha Insurance Company;** Attn: HFPP Policy Services P.O. Box 7200 Lancaster, SC 29721  
  The service department will send notification to the policyholder to advise of conversion rights and instructions for applying for conversion policy, if applicable |
| 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 (in the bottom left hand section of the page). Select Individual, Life & Supplemental (FPP), then filter (on left side of the page) by State, Audience, Document Type and Language. Once filters have been applied click search beneath filter section. Forms will populate on the right, scroll down to find document. If document being sought is not found, adjust filters and search again.
  **Provide the form to the policy owner to be completed and mailed:**  
  **Kanawha Insurance Company;** Attn: HFPP Policy Services, P.O. Box 7700, Lancaster, SC 29721
The policy owner or an alternate payer may be selected as the payer. However, an employer may not be named as a payer, and the payer 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.
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 Humana sales representative or call Agent Support.

Please refer to the Producer Partnership Plan for commission structure information. The document can be accessed through Agent Work Bench or by going to Humana.com/sellhumana.
Agent communications

You will be kept up-to-date on Humana 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

Humana 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 Humana products, and drive real results to your bottom line.

Contact your sales representative for details or to request advertising materials. Marketing materials may also be accessed online through the Agent Workbench (AWB).
No one plans to have an accident. Help your clients be prepared if it happens to them.

The Accident Benefit Plan is an accident only policy, and is great for those times when unexpected events lead to unexpected expenses. If you have been injured in an accident, payments for doctor visits, trips to the emergency room, even simple x-rays or stitches can add up very quickly.

This plan is an excellent complement to a medical plan, especially if the medical plan includes a high deductible.

- No deductibles, waiting periods, or maximum number of covered accidents.
- The plan requires no underwriting and there are no health questions when enrolling
- Reimbursed for actual out of pocket medical expenses for each covered accident up to the benefit amount selected.
- Get up to a $50,000 death benefit when caused by an accident based on the benefit amount selected
- 10-day free look period – STATE REQUIREMENTS MAY APPLY

Health underwriting guidelines

Health History Questions

There are no specific medical underwriting questions. The two questions asked are;

1. Does any person proposed for coverage have any existing accident insurance coverage in force or an application for similar insurance pending with this or any other company?

2. Will the policy applied for replace any coverage currently in force?

Regardless of how an applicant answers these questions, they will be eligible for the policy. The applicant may have another accident insurance plan in force and still obtain the Humana policy, as well. These questions are asked to ensure the appropriate paperwork is sent out if the applicant does plan on replacing their other plan.
Eligibility/issue ages

Plan Covers
This plan may cover the following:
• Individual (includes child only)
• Couple
• Single Parent – one parent and all children
• Family – two parents and all children

Issue Ages
The issue age is based on current age of the primary insured (age of last birthday)
• 0 – 75 (may vary by state)
• Policy must be purchased in the same state where the policyholder resides.

Dependent Children Coverage
A child may be listed as a dependent on their parents’ plan if:
• Available for insured’s children, including:
  - Newborn children/adopted children
  - Spouse’s children/adopted children
• Typically available to dependents who are less than 18 years of age or less than 26 years of age if a full-time student; and unmarried. Children age 18 or older and not a full-time student must apply on a separate application. This can vary by state.
• Available for mentally or physically disabled unmarried children who are supported by the insured and remain continuously disabled.

Effective dates
• The effective date is the day after the sign date of the application. Future dating is allowed up to 45 days from the date of the application. Policy effective dates must be between 1st and 28th of the month.
• If the application date is the 29th, 30th or 31st, the system will automatically update the effective date to the 1st of the next month.
• Backdating is not allowed.

Waiting period, limitations, and exclusions
There are no waiting periods for this plan. There are certain activities that are excluded from coverage. Please see benefit summary for more information.
Cash Cancer Plan

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

NOTE: The following information only explains your client’s possible 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.

• 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, varies by state
• 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
• 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 free look period

Eligibility/issue ages

• 18 – 69 for primary and for a family plan, a spouse can be up to age 74
• 0 – 17* for dependents:
  — Children must apply with a parent; child only coverage is not available
  — Age is based on the last birthday
  — 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
• Any application with a signature date of the 29th, 30th or 31st will be given an effective date that is the first of the following month
• Future effective date allowed for a maximum of 45 days from date of application
• Backdating is not allowed

* Dependent ages may vary by state. Please refer to the benefit summary.
Waiting period, limitations, and exclusions

• A 30-day waiting period exists 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.)
• Additional exclusions may apply. Please refer to the benefit summary

Tobacco usage

• 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)
• The rates are Tobacco/Non-tobacco. If any applicant is a tobacco user, the entire policy will receive tobacco rates.

• **Humana has two tobacco classes**
  1. Tobacco user
  2. 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 cancer coverage in-force with Humana/Kanawha (Critical Illness – Cancer and Cash Cancer) cannot exceed $50,000
• The total amount of cancer coverage in-force with Humana/Kanawha (Critical Illness – Cancer and Cash Cancer) and 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 policy will be issued provided all signatures are in place and the applicant(s) answered the health questions truthfully.

Ineligible condition list, including but not limited to

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

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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 free look period

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
  — Age is based on the last birthday
  — 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
- Any application with a signature date of the 29th, 30th or 31st will be given an effective date that is the first of the following month
- Future effective date allowed for a maximum of 45 days from date of application
- Backdating is not allowed

*Primary/Spouse/Dependent ages may vary by state. Please refer to the benefit summary.
Waiting period, limitations, and exclusions

- A 30-day waiting period exists 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.)
- Additional exclusions may apply. Please refer to the benefit summary.

Tobacco usage

- The rates are Tobacco/Non-tobacco.
  If any applicant has used tobacco in the last 12 months, the entire policy will receive 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
  1. Tobacco user
  2. 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 with Humana/Kanawha cannot exceed $50,000
- The total amount of Critical Illness coverage in-force with Humana/Kanawha and any carrier cannot exceed $100,000
- The total amount of coverage from All Carriers (including Humana/Kanawha) is $200,000 for all cancer or critical illness coverage

Health underwriting guidelines

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

- Health history that includes one of the ineligible conditions
- Height/weight that exceeds the limits identified in the build chart

Underwriting requirements

- Pharmaceutical is run on primary/spouse age 18 and above
- 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 process
- If an applicant does not have a primary care physician or has not had a physical exam in the past 3 years a physical exam will be required at the applicant’s expense
Age Appropriate Physical Exam Requirements (at applicant’s expense)

Age 60+ Female

You are required to have a current physical exam or send results of a recent exam if one was completed within the past 12 months. It will be your responsibility to pay for the exam and send the results. The physical exam must include exam notes including history and physical, height and weight, lipid panel, blood pressure, CBC (complete blood count), Chem-20 (SMA20), urinalysis, FOBT (fecal occult blood test), pap smear, and pelvic exam, along with clinical breast exam and mammogram.

Age 60+ Male

You are required to have a current physical exam or send results of a recent exam if one was completed within the past 12 months. It will be your responsibility to pay for the exam and send the results. The physical exam must include exam notes including history and physical, height and weight, lipid panel, blood pressure, CBC (complete blood count), Chem-20 (SMA20), urinalysis, FOBT (fecal occult blood test), prostate exam, and PSA blood test.

Build chart

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### Ineligible condition list, including but not limited to

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<th>Vascular</th>
<th>Other</th>
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<tr>
<td>Alcoholism, or alcohol, drug or substance abuse</td>
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<tr>
<td>Alzheimer’s disease</td>
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</tr>
<tr>
<td>Angina (heart related chest pain)</td>
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</tr>
<tr>
<td>Angioplasty</td>
<td></td>
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<td>Cancer</td>
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<td></td>
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</tr>
<tr>
<td>Cardiomyopathy</td>
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<tr>
<td>Cerebral vascular disease (stroke, TIA, mini-stroke)</td>
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<tr>
<td>Chronic lung disease</td>
<td>IC</td>
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</tr>
<tr>
<td>COPD</td>
<td>IC</td>
<td>IC</td>
<td>IC</td>
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<tr>
<td>Crohn’s disease</td>
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<td>Congestive heart failure</td>
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<td>Coronary artery disease</td>
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<td>Currently confined to a hospital, nursing home or other facility, or confinement recommended</td>
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<td>Diabetes - insulin dependent</td>
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<tr>
<td>Diabetes - type II</td>
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<td>Disease or disorder leading to permanent or progressive loss of vision or speech</td>
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<td>IC</td>
<td>IC</td>
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<tr>
<td>Emphysema</td>
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<td>Heart attack</td>
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<td>Heart bypass</td>
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<td>Heart defect - uncorrected</td>
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<td>Heart disease</td>
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<td>Heart valve disease</td>
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<td>Hemiplegia, paraplegia, quadriplegia</td>
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<td>x</td>
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<tr>
<td>Hepatitis, other than A</td>
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<td>Hodgkin’s disease</td>
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<tr>
<td>Hypertension/elevated blood pressure that is not controlled with medication</td>
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<td>x</td>
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<tr>
<td>Leukemia</td>
<td>x</td>
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</tr>
<tr>
<td>Lymphoma</td>
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<td></td>
</tr>
<tr>
<td>Malignant growth/tumors</td>
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<td>Multiple sclerosis</td>
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<td>Parkinson’s</td>
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<tr>
<td>Pending or recommended follow up, surgery or testing not completed</td>
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<tr>
<td>Peripheral vascular disease</td>
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<tr>
<td>Receiving hospice, home health care, or bedridden</td>
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<tr>
<td>Stent</td>
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<td>Stroke</td>
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<td></td>
</tr>
<tr>
<td>Symptoms of unknown etiology</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>Transient ischemic attack (TIA)</td>
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<td>x</td>
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<tr>
<td>Ulcerative colitis</td>
<td>IC</td>
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</table>
**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 free look period
- Premiums payable only on an annual basis

**Eligibility/issue ages**

- Issue age 0 – 24
- Age is based on nearest birthday
- Initial term coverage is to age 25
- Applicants and Owner 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
- Any application with a signature date of the 29th, 30th or 31st will be given an effective date that is the first of the following month
- Future effective date allowed for a maximum of 45 days from date of application

**Waiting period, limitations, and exclusions**

- No waiting period
- Two-year suicide exclusion

**Tobacco usage**

No tobacco rating

**Existing Humana/Kanawha coverage**

The rule for Junior Estate Builder coverage with Humana/Kanawha is one policy per person

**Underwriting requirements**

A “Yes” answer to question 1a, 1b or 2 on the application will require additional underwriting review

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

- Health history that includes one of the ineligible conditions
- Height/weight that exceeds the limits identified in the build chart

**Junior Estate Builder insured signature requirement:** Insured signature is required if 18 years and older except in PA and WA, which is 15 years or older
Ineligible condition list, including but not limited to

- AIDS/AIDS Related Complex (ARC), HIV
- Asthma – Individual Consideration
- Cancer
- Cystic Fibrosis
- Diabetes
- Drug abuse
- Heart abnormalities - uncorrected
- Hepatitis C
- Hydrocephalus
- Leukemia
- Lupus

### Build Chart

#### Birth to 18 months

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#### Ages 2 – 9

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#### Ages 10 – 13

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#### Ages 16 – 24

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</table>
Memorial Fund

Your client can relax, knowing their final wishes will be respected.

- 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*
- Ten Pay premium option provides a paid up insurance policy after premiums have been paid for 10 years

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
- Any application with a signature date of the 29th, 30th or 31st will be given an effective date that is the first of the following month
- Future effective date allowed for a maximum of 45 days from date of application

*Graded Death benefit not available in MA, NH, NJ, MT and WV.
**Issue age may vary by state. Please refer to the benefit summary.
Waiting period, limitations, and exclusions

- No waiting period
- Two-year suicide exclusion
- Exclusions apply for AD&D under the Graded Benefit option
- Additional exclusions may apply. Please refer to the benefit summary

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.

Health underwriting guidelines

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

- Height/weight that exceeds the limits identified in the build chart
- If any question is answered “YES” in section A on the application
- Health history that includes one of the ineligible conditions

Underwriting requirements

- An UW call will be completed on all Memorial Fund applications regardless if they answered no to all questions.

Ineligible condition list, including but not limited to

- 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

Build chart

<table>
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<td>371</td>
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</tbody>
</table>
Dental Loyalty Plus℠

The HumanaOne Dental Loyalty Plus plan offers loyal members increasing benefits from plan years one to three. These increasing benefits include paying less out-of-pocket for services like fillings, root canals, crowns, and other services; an increase in plan year annual maximums; a one-time deductible for as long as they’re on the plan; and no copayments or waiting periods. Most preventive services are covered at 100 percent. Also, the plan pays the same percentage no matter which dentist they visit. They can save even more by choosing one of the more than 225,000 dentist locations in the HumanaOne Dental Loyalty Plus network.

Loyalty Plus plan features

• Increased coverage for procedures such as fillings, root canals, and crowns
• Increased maximum amounts that the plan will pay annually
• One-time deductible for as long as you stay on the plan
• Choice – Freedom to visit the dentist they like most
• Access to benefits – No waiting periods, your clients can get the dental work they need upon their effective date and their plan benefits will help cover the cost
• Helps maintain good oral health – Most preventive services are covered at 100 percent

One-time deductible

Individual $150
Individual + One $300
Family $450

Plan year annual maximum

(Annual maximum is the most the plan will pay toward services in a plan year.)

First year $1,000 per individual on the plan
Second year $1,250 per individual on the plan
Subsequent years $1,500 per individual on the plan
Submitting applications
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.

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 in advance of the coverage 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 SUMMARY OF BENEFITS FOR ADDITIONAL DETAILS.

Cancellation limitation
Because of the one-year contract, cancellation during the free look period is limited to the following conditions: Your clients may cancel within 10 days of their initial effective date (except New Hampshire, which is 30 days from effective date).*

* If your client cancels their membership within the 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 canceled within the cancellation period. Association membership will automatically be canceled.
HumanaDental® Smart Choice

The Humana Dental Smart Choice plan is designed for individuals and families who believe in the importance of regular dental care. Members can maximize benefits by choosing one of the more than 225,000 dentist locations in the Humana Dental PPO network. There’s no age requirement and your clients will never be turned away for pre-existing conditions. The plan starts the first month of eligibility.

The Humana Dental Smart Choice Plan can only be purchased through the federal or state marketplaces when your client enrolls in a health plan. They may elect coverage during the Open Enrollment period. Outside of the Open Enrollment period, clients can change health and dental plans if they have a qualifying life event such as moving to a new state, certain changes in income or change in family size.

Who can enroll for this plan – Any individual or family can apply for this plan. There are only three requirements: They must live in the U.S., they must be U.S. citizens or national (or lawfully present), and they cannot be currently incarcerated (www.healthcare.gov/marketplace/about/eligibility).

Date the plan starts – Applications received between the 1st and the 15th of the month will be effective on the 1st of the next month. Applications received between the 16th and the 31st of the month will be effective on the 1st of the following month. For example, an application received February 5 will have an effective date of March 1, and an application received February 17 will have an effective date of April 1.
Submitting applications

Applications can be submitted online through the federal or state exchange marketplaces. During Open Enrollment you can also enroll your clients through your unique agent link that can provide to them.

SEE YOUR STATE-SPECIFIC SUMMARY OF BENEFITS FOR ADDITIONAL DETAILS.

<table>
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<tr>
<th></th>
<th>Adult</th>
<th>Pediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$50 – $100</td>
<td>$35 – $125</td>
</tr>
<tr>
<td><strong>Annual maximum</strong></td>
<td>$1000</td>
<td>No annual maximum</td>
</tr>
<tr>
<td><strong>Maximum out of pocket</strong></td>
<td>Out-of-pocket maximum for a policy with one covered child is $350. The out-of-pocket maximum for a policy with two or more covered children is $350 per individual child or $700 combined for all children.</td>
<td></td>
</tr>
</tbody>
</table>
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 225,000 dentist locations, they’re sure to find a dentist they know who practices near their home or work. Your clients 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 percent
• Many commonly used basic services are covered at 50 percent (after deductible), waiting periods may apply
• Discounts may be available on other basic and major services when using network providers
• Savings by choosing network dentist

Annual deductible

• $50 individual
• $150 family

Annual maximum benefit

$1,000 per member, per calendar year.

Submitting applications

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Plan administration

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25 Preventive Plus dental plan
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.

Prepaid HI215 plan features

- Preventive services – no copayment ($15 office visit charge may apply)
- Basic and major services – copayments apply (charges vary by procedure)
- Orthodontia discount – May receive up to a 25 percent discount if visiting a participating orthodontist and your client asks for the discount
- Discount may be available on non-covered specialty services if you visit a provider from the network and your client asks for the discount

Submitting applications

- 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.

Plan administration

- Applications received and completed from the first through the 15th of the month will be effective the first of the following month. Applications received the 16th through the end of the month will be effective the first of the subsequent month. (Ex: Application received on the 16th 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 in advance of the coverage month.

SEE YOUR STATE-SPECIFIC SUMMARY OF BENEFITS FOR ADDITIONAL DETAILS.

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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.

Prepaid C550 plan features

• Preventive services—no copayment ($10 office visit charge may apply)
• Basic and major services—copayments apply (charges vary by procedure)
• Orthodontia discount—May be up to a 25 percent discount if they visit a participating orthodontist and your client asks for the discount
• Discounts may be available on non-covered specialty services if your client visits a provider from the network and your client asks for the discount

Submitting applications

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Plan administration

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Vision Care Plan

Vision Care 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

Submitting applications

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Plan administration

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Cancellation limitation

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Your clients may cancel within 10 days from their initial effective date.

Vision Focus Plan

Vision Focus 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

Submitting applications

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.

Plan administration

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Cancellation limitation

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Your clients may cancel within 10 days from their initial effective date.
This brochure is intended to provide a high level overview of Humana 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.

These policies provide limited benefits.

**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**

**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**
Humana 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.

**Accident Benefit Plan**
Accident Benefit Plan is an accident product underwritten by Kanawha Insurance Company. Policy form 60860.