Vision Coverage for the Employees of:
University of North Alabama

Effective June 1, 2009

Thank you for considering HumanaVision plans. Let us help preserve and improve your sight.

The choice for vision care is clearly simple: HumanaVision plans.

- **One price.** HumanaVision plans make eye care affordable. Benefits are the same at all participating providers in the network, no matter where they're located or what their typical retail charges are. Wholesale pricing ensures affordable frames, lens options and upgrades for all members at the same price.

- **More choices, more convenience.** You have access to one of the largest vision networks in the United States, with more than 22,500 participating optometrists and ophthalmologists. Every one accepts new patients, and many have evening and weekend hours.

- **Service excellence.** We make it easy for your employees, too. They can:
  - Call Humana Customer Care at 1-866-537-0229 from 8 a.m. – 8 p.m. Monday – Thursday and 8 a.m. – 6 p.m. Friday, Eastern time.
  - View benefits, check claims and access other services at HumanaVisionCare.com.

Humana will add tremendous value to your benefits package.
Focus on wellness

With all of the choices available regarding your benefits, vision care is a relatively simple yet valuable benefit, and is important for your well-being and overall health. Humana is dedicated to preserving employees’ eye health and wellness, while focusing on choice and value.

Early detection of vision problems is critical
The leading causes of irreversible blindness—glaucoma, diabetic retinopathy, cataracts, and muscular degeneration—advance without pain and other symptoms in their earliest stages. Eighty percent of the world’s blindness is preventable, according to the International Agency for the Prevention of Blindness.

Focusing on the facts of vision
➢ A vision plan is one of the top five most-desired benefits, after medical insurance, by employees. ¹
➢ More than 75 percent of U.S. residents between age 25 and 64 require some sort of vision correction.²
➢ Vision problems affect 120 million Americans.³
➢ More than 70 percent of Americans reported loss of eyesight as “10” on a scale of 1—10, with 10 being the worst thing that could happen to them. It means a loss of independence, mobility and quality of life.⁴

Vision health impacts overall health
Periodic eye examinations are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, our employees may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.⁵ Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.⁶

Employee Rates:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Employee Only</th>
<th>Employee + One</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$ 4.44</td>
<td>$ 8.88</td>
<td></td>
</tr>
<tr>
<td>Employee + One</td>
<td>$ 8.88</td>
<td>$17.76</td>
<td></td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$11.88</td>
<td>$23.76</td>
<td></td>
</tr>
</tbody>
</table>

¹ LIMRA International
² Jobson’s Optical Research
³ Vision Council of America
⁴ National Eye Institute and Lions Clubs International Foundation
⁵ American Optometric Association
⁶ Thompson Media Inc.
**Vision Care Plan**

<table>
<thead>
<tr>
<th>Vision care services</th>
<th>Visit a participating provider</th>
<th>Visit a nonparticipating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam/materials co-pay*</td>
<td>$20/$20</td>
<td></td>
</tr>
<tr>
<td>Exam with dilation as necessary</td>
<td>100% after co-pay</td>
<td>$35 allowance</td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>100% after co-pay</td>
<td>$25 allowance</td>
</tr>
<tr>
<td>Bifocal</td>
<td>100% after co-pay</td>
<td>$40 allowance</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100% after co-pay</td>
<td>$60 allowance</td>
</tr>
<tr>
<td>Progressive (levels 1-4)</td>
<td>100% after co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$50 wholesale frame allowance</td>
<td>$40 retail allowance</td>
</tr>
<tr>
<td><strong>Contact lenses</strong></td>
<td>$150 Contact lens allowance</td>
<td>$150 Contact lens allowance</td>
</tr>
<tr>
<td>Elective (conventional and disposable)</td>
<td>100%</td>
<td>$210 allowance</td>
</tr>
<tr>
<td>Medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency</strong> (based on date of service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Lenses or contact lenses</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Frame</td>
<td>Once every 24 months</td>
<td>Once every 24 months</td>
</tr>
</tbody>
</table>

* Material co-pay is required for a complete pair of eyeglasses, lenses or frames.
** If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of lenses.

**How does the wholesale frame allowance work?**

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, members pay twice the wholesale difference. They never pay full retail.

**Lasik and PRK procedures**

Members receive substantial reductions when procedures are done by network providers.

Members can expect to pay no more than $1,800 per eye for conventional Lasik procedures and $2,300 per eye for custom Lasik or they can use designated TLC Vision Lasik Advantage Centers that have the following fixed prices:

- Conventional Lasik: $895 per eye
- Custom Lasik: $1,295 per eye
- Custom Lasik with IntraLase: $1,895 per eye

**Additional plan discounts**

- Members receive additional fixed co-payments on lens options including: anti-reflective and scratch-resistant coating, etc.
- The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members receive a 15% discount on professional services. The discount for professional services is available for 12 months after the covered eye exam.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the VCP network provider who sold the initial pair of eyeglasses.
- After co-pay, standard polycarbonate available at no charge for dependents less than 19 years old.

*Proprietary to Humana Insurance Company*
Progressive lenses are covered in full with your materials.

### Lens Type
- **Level 1 Progressive**
- **Level 2 Progressive**
- **Level 3 Progressive**
- **Level 4 Progressive**

### Average Multi focal Cost - Retail
- **Level 1 Progressive**: $165.00
- **Level 2 Progressive**: $180.00
- **Level 3 Progressive**: $190.00
- **Level 4 Progressive**: $295.00

### Your Cost with vision plan
- $20 Materials co-payment

### Progressive Availability

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Image</td>
<td>AO Compact</td>
<td>AO Outlook</td>
<td>AO B’Active</td>
</tr>
<tr>
<td>Kodak</td>
<td>AO Omni</td>
<td>Essilor Ovation</td>
<td>Hoya Summit CD</td>
</tr>
<tr>
<td>Navigator</td>
<td>Essilor Natural</td>
<td>Kodak Precise</td>
<td>Hoya Summit ecp</td>
</tr>
<tr>
<td>Navigator Short</td>
<td>Kodak Concise</td>
<td>Rodenstock AT</td>
<td>Hyperview</td>
</tr>
<tr>
<td>Pentax AF</td>
<td>Rodenstock XS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pentax AF Mini</td>
<td>Sola Percepta</td>
<td>KbCo Fusion 1</td>
<td></td>
</tr>
<tr>
<td>Silor Adaprt</td>
<td>Varilux Comfort</td>
<td>Rodenstock Life 2</td>
<td></td>
</tr>
<tr>
<td>Sola Max</td>
<td>Varilux Liberty</td>
<td>Varilux Eclipse</td>
<td></td>
</tr>
<tr>
<td>VIP</td>
<td>Zeiss Gradal Top</td>
<td>Varilux Panamic</td>
<td></td>
</tr>
<tr>
<td>XL</td>
<td>Hoyalux Wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoyalux GP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**HUMANA.**

*Specialty Benefits*
You can save money two ways with VisionCare

First, the cost of plan services and materials is discounted and prepaid. So except for any copays, you have no out-of-pocket expenses for covered services and supplies. Second, if you are under a Section 125 program you pay for coverage on a pre-tax basis.

Your coverage costs are deducted from your pay before any federal income or FICA taxes are taken out. This makes your taxable wage base lower, so you would pay less tax.

Here's an example of how the plan helps you save over the course of a year:

<table>
<thead>
<tr>
<th>If You Get:</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VisionCare Doctor</td>
</tr>
<tr>
<td>Eye exam</td>
<td>0</td>
</tr>
<tr>
<td>Frame (fashion style)</td>
<td>0</td>
</tr>
<tr>
<td>Lenses: Varilux Comfort Progressive Bifocals‡</td>
<td>0</td>
</tr>
<tr>
<td>Option (pink tint #1 or #2)</td>
<td>0</td>
</tr>
<tr>
<td>Copayment: $20 exam/$20 materials</td>
<td>$40.00</td>
</tr>
<tr>
<td>Premium ($8.88 per month x 12 months)</td>
<td>$106.56</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>$146.56</strong></td>
</tr>
<tr>
<td>Pre-tax payment: Tax savings (assuming 18% tax bracket &amp; 7.65% FICA)</td>
<td>$-27.33</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td><strong>$119.23</strong></td>
</tr>
</tbody>
</table>

**YOUR TOTAL SAVINGS THROUGH VISIONCARE: 70% OFF RETAIL**

In this example, you would have saved $290.77 in vision care costs with VisionCare Plan. Keep in mind, however, that your actual savings will depend on your plan allowances, your actual premium, the doctors and materials you select, and your own tax situation.
Vision health impacts overall health
Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.¹

¹ Thompson Media Inc.

Use your HumanaVision VCP benefits
HumanaVision VCP options have you covered and make eye care affordable. You have access to one of the largest vision networks in the United States, with more than 22,500 participating optometrist and ophthalmologists. In addition you’ll enjoy:

› The same benefits at all participating providers, no matter where they’re located
› Wholesale pricing on frames, avoiding high retail markups
› Simple access to plan information, provider search, Customer Care and other automated services at HumanaVisionCare.com

How it Works
1. After signing up for the Vision Care Plan, members will receive an ID card in the mail
2. Prior to scheduling your appointment, select a network provider through the Customer Care Center, automated information line, or HumanaVisionCare.com
3. Schedule an appointment, providing your name, the patient’s name and employer
4. Sign your provider’sVCP form after your exam, you’ll pay any copayments and/or costs of any upgrades at this time

Know what your plan covers
Attached is a summary of HumanaVision VCP benefits that are described in detail in your certificate. You can find your certificate on HumanaVisionCare.com or call 1-866-537-0229. Here’s what you can expect:

› Quality routine eye health care from independent eye care professionals
› Services and materials provided on a prepaid basis, and the plan pays in-network providers directly, you also have the freedom to use out-of-network providers if you prefer
› Life without claim forms! With HumanaVision VCP, you pay your eye care professional directly for copayments and any extra cosmetic options selected at the time of service
› Select a vision provider from our network simply by visiting HumanaVisionCare.com, if you prefer, call us at 1-866-537-0229

Know what your plan doesn’t cover
Some items and services not included in HumanaVision VCP are:

› Orthoptics or vision training, subnormal vision aids or Plano (non-prescription) lenses
› Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
› Medical or surgical treatment of eyes
› Care provided through or required by any government agency or program, including Workers’ Compensation or a similar law

Questions?
Check out HumanaVisionCare.com

Call Customer Care at 1-866-537-0229 from 8 a.m. - 8 p.m., Monday - Thursday, and 8 a.m. - 6 p.m. Friday, Eastern time.

HUMANA.
Specialty Benefits
Vision products insured by Humana Insurance Company or CompBenefits Insurance Company

This is not a complete disclosure of plan qualifications and limitations. Check with your local Humana or HumanaDental sales office to verify product availability.

GN-51514-HV 3/08
Humana Large Group Employee Enrollment Form

The offering company(ies) listed on the signature page, severally or collectively, as the context may require, are referred to in this application as "Humana". Print clearly and completely fill in each applicable circle.

Company name: University of North Alabama
Company city: Florence
State: AL

Office use only:
Qualifying event:
- Open Enrollment
- Re-hire
- New hire
- Changed to full time status

Qualifying event date (MM/DD/YYYY):
Benefit effective date (MM/DD/YYYY):

Employee Information

Last name: ____________________________
First name: ____________________________
MI: ____________________________
Social security number: ____________________________
Date of birth (MM/DD/YYYY): ____________________________
Area code: ____________________________
Phone number: ____________________________
Street address: ____________________________________________
Apt / Suite / PO box number: ____________________________
Gender: Male, Female
Language of choice: English, Spanish
City: ____________________________
State: ____________________________
Zip code: ____________________________
County / Parish: ____________________________
E-mail address: ____________________________
Employment status: Full-time employee, Retiree
Date of full-time hire (MM/DD/YYYY): ____________________________

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

Dependent Information

Enter information for each covered dependent, including spouse.

1. Dependent last name: ____________________________
First name: ____________________________
MI: ____________________________
Gender: Male, Female
Date of birth (MM/DD/YYYY): ____________________________
Relationship: Spouse, Child, Other
Dependent status (if applicable): Full-time student (18 or older), Disabled
If disabled, indicate reason: ____________________________

2. Dependent last name: ____________________________
First name: ____________________________
MI: ____________________________
Gender: Male, Female
Date of birth (MM/DD/YYYY): ____________________________
Relationship: Spouse, Child, Other
Dependent status (if applicable): Full-time student (18 or older), Disabled
If disabled, indicate reason: ____________________________

3. Dependent last name: ____________________________
First name: ____________________________
MI: ____________________________
Gender: Male, Female
Date of birth (MM/DD/YYYY): ____________________________
Relationship: Spouse, Child, Other
Dependent status (if applicable): Full-time student (18 or older), Disabled
If disabled, indicate reason: ____________________________

Reorder# AL-80124-LG 3/2008
Dependent last name
First name
MI
Gender
Female
Male
Date of birth (MM/DD/YYYY)
Relationship
Spouse
Child
Other:
Dependent status (If applicable): Full-time student (18 or older)
Disabled
If disabled, indicate reason:
Use the following alternate address for these dependents: 1 2 3 4
Street address
Apt / Suite / PO box number
City
State
Zip code
County / Parish
Vision
Coverage type:
Employee only
Employee & spouse
Family
Employee & child(ren)
Other:
Office use only
Group #
Benefit #
Class/Div #
Plan name
Waiver (Refusal) of Coverage
I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):
Vision for:
Myself
My spouse
My dependent child(ren)
I decline to apply for group coverage because of:
Spousal coverage
Medicare supplement
Individual coverage
Coverage under another carrier’s plan provided by my employer
Other:
Insuring companies

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". Medical, Life, Vision and Short-Term income Protection plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company, Humana Insurance Company or CompBenefits of Alabama, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

True and complete acknowledgement:

I understand, agree and represent:

- I have read this application or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/ certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment with in 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

Authorization

I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy office.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

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

Employee or legal representative signature

Date

Name and relationship of legal representative

AL-22001-AV 1/2005

Reorder: AL-80124-AA