



Administrative Office:
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Austin, TX 78746
(512) 338-6100

Humana Health Plan of Texas, Inc.

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Group Plan Sponsor: V&L MANAGEMENT

Master Group Contract Number: 736995

Effective Date of Master Group Contract: 12/01/2016 **Product Name:** TXFF0003 COIN

Terms printed in italic type in this *master group contract* have the meaning indicated in the "Glossary" and "Glossary – Pharmacy Services" sections of the *evidence of coverage*.

This *master group contract* is delivered in and governed by the laws of: TX.

Humana Health Plan of Texas, Inc. agrees, subject to all the terms and provisions of this *master group contract*, to pay benefits as described in the *evidence of coverage*, incorporated by reference herein, with respect to each *covered person* under this *master group contract*. Humana Health Plan of Texas, Inc. and the *group plan sponsor* have agreed to all of the terms of this *master group contract*.

The *master group contract* is issued in consideration of the Employer Group Application of the *group plan sponsor*, incorporated by reference herein, and such *group plan sponsor's* payment of premium as provided under this *master group contract*.

This *master group contract* and the coverage it provides become effective at 12:01 A.M. (Standard Time) of the effective date stated above. This *master group contract* and the coverage it provides terminates at 12:00 A.M. (Standard Time) of the date of termination. The provisions stated above and on the following pages are parts of this *master group contract*.



Bruce Broussard
President

"We have also arranged for *health coverage* to be provided to *covered persons* for services and supplies not obtained through *network providers* of Humana Health Plan of Texas, Inc. This arrangement is a benefit under the terms of this *master group contract*, and the policy issued by Humana Insurance Company, Inc. outlines the scope of coverage and the manner in which the *health coverage* provided by Humana Insurance Company may be used." *Covered persons* are not required to first use the benefits offered by Humana Health Plan of Texas, Inc. prior to utilizing the benefits outlined in the attached policy insured through Humana Insurance Company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT REPLACE WORKERS' COMPENSATION INSURANCE. THE *EMPLOYER* DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS *POLICY*, AND IF THE *EMPLOYER* IS A NON-SUBSCRIBER, THE *EMPLOYER* LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE *EMPLOYER* MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS MASTER GROUP CONTRACT IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from *us*.

1. IMPORTANT NOTICE

To obtain information or make a complaint:

2. You may call Humana Health Plan of Texas Inc.'s toll-free telephone number for information or to make a complaint at:

1-866-4ASSIST

3. You may also write Humana Health Plan of Texas Inc. at:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

5. You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

6. PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

7. ATTACH THIS NOTICE TO YOUR POLICY/EVIDENCE OF COVERAGE:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Humana Health Plan of Texas Inc.'s para obtener información o para presentar una queja al:

1-866-4ASSIST

Usted también puede escribir a Humana Health Plan of Texas Inc. al:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Sitio Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con a su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA/EVIDENCIA DE COBERTURA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

SUBSIDIARIES OR AFFILIATES

Any *employer*, which is a subsidiary or affiliate of a *group plan sponsor*, is eligible for coverage under this *master group contract* if the following conditions are met:

- The subsidiary or affiliate is a company owned and controlled by the *group plan sponsor*, files a combined tax return and is listed in the Employer Group Application of the *group plan sponsor*, or in any amendment thereto;
- The *group plan sponsor* and the subsidiary or affiliate are members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code; and
- The subsidiary or affiliate has been approved for coverage under this *master group contract* in writing or by *electronic mail*, by both the *group plan sponsor* and *us*.

For the purposes of this *master group contract*, an *employee* of such a subsidiary or affiliate of the *group plan sponsor* shall be considered to be an *employee* of the *group plan sponsor*.

A subsidiary or affiliate of a *group plan sponsor* shall cease to be eligible for coverage under this *master group contract* on the earliest of the following:

- The end of the month in which the *group plan sponsor* and the subsidiary or affiliate are no longer members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code;
- The end of the month, following a 60 day written notice, in which the subsidiary or affiliate has relocated outside of the *service area* and no *covered person* resides, lives, or works in the *service area*;
- The end of the month in which the *group plan sponsor's* written notice of its intent to terminate the participation of the subsidiary or affiliate is received by *us*, or on any later date as may be stated in such notice; or
- The end of the month in which this *master group contract* terminates.

The coverage of any *employee* of a subsidiary or affiliate of a *group plan sponsor* and the coverage of such *employee's* covered *dependents*, shall terminate at the end of the month in which the subsidiary or affiliate ceases participation under this *master group contract*.

REQUIREMENTS FOR COVERAGE

Eligibility

The *group plan sponsor* must indicate on the Employer Group Application the *employees* eligible under this *master group contract*, if applicable, as defined below:

- All *employees* of a *small employer* who meet the *evidence of coverage* definition of an *eligible employee*. An *eligible employee* must be in *active status*, working the number of hours indicated on the Employer Group Application. An *eligible employee* may also include sole proprietors, partners, corporate officers, and independent contractors if the *group plan sponsor* makes specific reference that sole proprietors, partners, corporate officers or independent contractors be included and meet the definition of an *eligible employee* as defined in the *evidence of coverage*.
- All *employees* of a *large employer* meeting the *participation criteria* established by the *large employer*.
- The *group plan* may also provide coverage for retired *employees* and their *dependents*. Retirees will be eligible only if the *group plan sponsor* requests such coverage, and it is approved by *us*.
- Part-time *employees* may also be included as eligible for coverage under this *master group contract* if the *group plan sponsor* makes specific reference that part-time *employees* are included, and it is approved by *us*.
- The *dependents* of an *employee* may be eligible for coverage under this *master group contract* if they meet the *evidence of coverage* definition of *dependent* and if the *employee* is covered under this *master group contract*.

Date eligible

Each *group plan* may provide one of the following as the *eligibility date* for *employees* and *dependents* as provided by this *master group contract*. The *group plan sponsor* must elect the *eligibility date* on the Employer Group Application. *Eligibility date* options include immediate eligibility or first of the month eligibility as outlined below.

Immediate eligibility

Each *eligible employee* of a *small employer* included on, or after, the date the *employer* becomes a *group plan sponsor* will be eligible under this *master group contract* on that date, provided the required *waiting period* has been completed, if any, as indicated on the Employer Group Application.

Each *eligible employee* meeting the *participation criteria* of a *large employer* included on, or after, the date the *employer* becomes a *group plan sponsor* will be eligible under this *master group contract* on that date, provided the required *waiting period* has been completed, if any, as indicated on the Employer Group Application.

REQUIREMENTS FOR COVERAGE (continued)

First of the month eligibility

Each *eligible employee* of a *small employer* included after the date the *employer* becomes a *group plan sponsor* will be eligible under this *master group contract* on the first day of the next following calendar month, or on the first day of the next following calendar month after the completion of the required *waiting period*, if any, as indicated on the Employer Group Application or as otherwise agreed to by the *group plan sponsor* and *us*. A *small employer* may establish a *waiting period* not to exceed 90 days from the first day of employment.

Each *eligible employee* meeting the *participation criteria* of a *large employer* included after the date the *employer* becomes a *group plan sponsor* will be eligible under this *master group contract* on the first day of the next following calendar month, or on the first day of the next following calendar month after the completion of the required *waiting period*, if any, as indicated on the Employer Group Application or as otherwise agreed to by the *group plan sponsor* and *us*. A *large employer* may establish a *waiting period* not to exceed 90 days from the first day of employment.

Enrollment

Each *employee* must complete the enrollment process to enroll for coverage under the *master group contract* for himself or herself and their eligible *dependents*, if any, as outlined in the "Enrollment" provision within the "Eligibility and Effective Dates" section of the *evidence of coverage*.

Health status will not be used to determine premium rates. We will not use *health status-related factors* to decline medical coverage to an *eligible employee* or eligible *dependent*. We will administer this provision in a non-discriminatory manner.

Employee evidence of coverage

A *evidence of coverage* setting forth a statement of benefits the *employee* and the *employee's* covered *dependents* are entitled will be available at www.humana.com or by hardcopy when requested. The *employer* is responsible for providing *employees* access to the *evidence of coverage*.

Group plan sponsor responsibility for compliance with certain federal laws

If the *group plan sponsor* is contracting with *us* in connection with a health plan that is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the following apply:

REQUIREMENTS FOR COVERAGE (continued)

Group plan sponsor as plan administrator

The *group plan sponsor* shall serve as the "plan administrator" (as that term is defined by ERISA) and is solely responsible for administering its employee welfare plan (the "plan"). Those responsibilities include, but are not limited to:

- Complying with any federal, state or local law or regulation that may apply to the *group plan sponsor* as policyholder, plan sponsor or as plan administrator;
- Providing *covered persons* with all notices and documents required by such laws and regulations; and
- Applying the eligibility requirements described in this *master group contract*.

Summary plan description compliance

The *group plan sponsor* shall assure that each plan participant eligible to enroll for benefits under the *policy* is given, on a timely basis, a Summary Plan Description (SPD) and/or Notice of Material Modification to a previously delivered SPD, when and in the manner required by ERISA. The *group plan sponsor* warrants that each such SPD (and any Notice of Material Modification relating thereto) shall, to the extent required by ERISA (including any regulation adopted to implement ERISA), incorporate:

- As the plan's claims processing and review procedures, *our* claims processing and review procedures, including the review, appeal, grievance and external review procedures that *we* must provide under applicable law; and
- A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a *covered person* might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by ERISA.

The *group plan sponsor* acknowledges that there is no exception to ERISA's SPD and related disclosure requirements for *small employers*.

Humana has developed a Plan Overview Document to assist *employers* in complying with ERISA SPD requirements. This document and other enrollment materials are available at www.humana.com.

Cooperation

On request, the *group plan sponsor* shall promptly provide *us* with copies of its plan document, SPD, Notices of Material Modifications and/or verification of the plan's status as subject to ERISA as *we* may require:

- To verify compliance with this section;
- To assist *us* in connection with any actual or threatened denied benefit, subrogation or other litigation; or
- As otherwise required by *us* for regulatory compliance or other legitimate business purpose.

PARTICIPATION REQUIREMENTS

The *group plan sponsor* must maintain *our* minimum participation and contribution requirements, as specified in the underwriting requirements of the Employer Group Application.

RENEWAL AND TERMINATION PRIVILEGE

Right to not renew or terminate this master group contract

The *group plan sponsor* may terminate this *master group contract* by giving written notice to *us* no later than 31 days prior to the desired termination date.

The *group plan sponsor* may terminate the coverage provided under any provision of this *master group contract*, with *our* consent, by giving written notice to *us* as of a date mutually agreeable to the *group plan sponsor* and *us*.

The *large employer* may terminate coverage for *covered persons* who no longer meet the *participation criteria* of the *large employer*.

We may terminate this *master group contract*, as allowed by applicable law, by giving written notice to the *group plan sponsor*. Written notice will be mailed no later than 31 days prior to the termination date, except as otherwise outlined under this provision.

We may refuse to renew or we may terminate the *master group contract* if:

- The end of the month in which *group plan sponsor* fails to pay *us* any premium due necessary to maintain the coverage provided by both Humana Health Plan of Texas, Inc. and Humana Insurance Company when due, except coverage will continue during the grace period.
- The end of the month in which *group plan sponsor* has failed to comply with *our* minimum participation or contribution requirements, as specified in the underwriting requirements of the Employer Group Application.
- The end of the month, following a 30 day written notice, in which no *covered person* resides, lives, or works in the *service area*.
- The *group plan sponsor* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. We may terminate the *master group contract* with at least 15 days prior written notice to the *group plan sponsor* for instances of fraud or intentional misrepresentation of a material fact.
- We decide to discontinue offering a particular group health plan:
 - The *group plan sponsor* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
 - The *group plan sponsor* will be given the option to purchase all other group plans providing medical benefits that is being offered by *us* at such time.

RENEWAL AND TERMINATION PRIVILEGE (continued)

The *group plan sponsor* will again be notified by *us* in writing of such discontinuation 30 days prior to the discontinuance date.

- We cease to do business in either the *small employer* or the *large employer* group medical market, as applicable and as allowed by the state requirements. If we cease doing business in the *small employer* or the *large employer* group market, the *group plan sponsors*, *covered persons*, and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

The *group plan sponsor* will again be notified by *us* in writing of such discontinuation 30 days prior to the discontinuance date.

Effect of termination of this agreement

Upon termination of this *master group contract*, it is the *group plan sponsor's* obligation to notify all *employees* of such termination, except for the specific situations outlined in the "Right to not renew or terminate this master group contract" provision. If the *group plan sponsor* requires a contribution from the *employees* to offset a portion of the premium, it is the responsibility of the *group plan sponsor* to refund to those *employees* the portion of the contribution, if any, which the *group plan sponsor* may have collected for any period of time following the termination of this *master group contract*.

Our obligation to offer continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to *covered persons* ends on the date the *master group contract* terminates. *Our* obligation to offer continuation coverage to *covered persons* under any other applicable law ends on the date this *master group contract* terminates or on such date as may be required under the applicable continuation of coverage law. It shall be the responsibility of the *group plan sponsor* to secure continuation of coverage for *covered persons* whose continuation rights run beyond the termination of this *master group contract*.

Termination of coverage

Unless otherwise agreed to by the *group plan sponsor* and *us*, termination of coverage will occur following any of the events listed below:

- The end of the month in which this *master group contract* terminates in accordance with its terms and conditions;
- The termination date according to the "Right to not renew or terminate this master group contract" provision;
- The date the *group plan sponsor*, acting with *our* knowledge and consent, deletes an optional benefit under this *master group contract* (termination under this paragraph will occur only with respect to such deleted optional benefit coverage);

RENEWAL AND TERMINATION PRIVILEGE (continued)

- The end of the month in which the *group plan sponsor*, acting with *our* knowledge and consent, deletes *employees* eligible under this *master group contract*, if applicable, from the *group plan sponsor's* plan (termination under this paragraph will occur only with respect to *covered persons* no longer meeting the large employer's participation criteria or will occur with respect to all *covered persons* of a *small employer*); or
- The *group plan sponsor*, acting with *our* knowledge and written consent, terminates any provision of this *master group contract* (termination under this paragraph will occur on a date mutually agreeable to the *group plan sponsor* and *us*).

Rescission, reduction of coverage or increase past premium

We reserve the right to *rescind* this *master group contract* and any *evidence of coverage* issued due to fraud or an intentional misrepresentation of a material fact. We will provide a 30 calendar day advance written notice to the *group plan sponsor* and affected *employee(s)* before coverage is *rescinded* and it will include appeal rights as may be required by law. This provision is subject to the Incontestability provision, refer to the "Miscellaneous Provisions" section of the *evidence of coverage*.

We reserve the right to reduce coverage in accordance with applicable law. We may apply this provision to one or all *covered persons* when such *covered person(s)*, the *employer* or other person(s) provides or has provided incomplete, inaccurate or untimely information on any enrollment form, Employer Group Application or any other eligibility form, if such information materially affected the acceptance of the *group*, the *covered person*, or the risk.

We reserve the right to increase past premium in accordance with applicable law. We may apply this provision to all *covered persons* when such *covered person(s)*, the *employer* or other person(s) provides or has provided incomplete, inaccurate or untimely information on any enrollment form, Employer Group Application or any other eligibility form, if such information materially affected the acceptance of the *group*, the *covered person*, or the risk.

If no claims have been paid under this *master group contract* up to the date coverage is *rescinded* or reduced, we will return premiums paid for such coverage to the *group plan sponsor*.

If claims have been paid under this *master group contract* before the date coverage is *rescinded* or reduced, we reserve the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the *group plan sponsor*. The *covered person* is responsible for any amount of claims in excess of the premium paid.

Reinstatement

If the *master group contract* terminates, it may be reinstated at *our* option. Reinstatement requests must be submitted in writing by the *group plan sponsor*, are subject to *our* approval and are not guaranteed.

Any premium accepted in connection with a reinstatement will be applied to the period for which the premium was not previously paid.

A *group plan sponsor* that requests reinstatement will be assessed a Reinstatement Fee.

PREMIUMS

Payment of premiums

Unless otherwise agreed to by *us*, the first premium is due on the *group plan sponsor's* effective date under this *master group contract* and subsequent premiums are due on the first of each calendar month thereafter.

Premiums should be sent to the designated location on the premium statement. Premiums will be recorded as paid on the date *we* receive the payment. If there are not sufficient funds in the designated bank account on the date that premiums are deducted, the *group plan sponsor* will be assessed an insufficient funds fee.

Premium statement

A premium statement will be prepared in accordance with the billing method *we* arrange with the *group plan sponsor*. This premium statement will show the premium due. It will also reflect any pro-rata premium charges and credits resulting from changes in the number of *covered persons* and changes in the amounts of coverage that took place during the period following the last premium statement. In the event that notice of termination of coverage, or a decrease in coverage, for a *covered person* is received by *us* more than one month after the termination of coverage or decrease of coverage, retroactive premium credit will not be permitted. The *group plan sponsor* is liable for premiums on the *covered person* from the time the *covered person* is no longer eligible for coverage under this *master group contract* until the end of the month in which *we* are notified by the *group plan sponsor* that the *covered person* is no longer eligible for coverage under this *master group contract*. The individual remains a *covered person* under this *master group contract* until the end of that period.

Premium rate change

As permitted by applicable law, *we* reserve the right to change any premium rate, including on a retrospective basis when:

- The terms of the *master group contract* are changed by *us*; or
- *Our* liability has been altered, in *our* opinion, because of:
 - A change in state or federal law; or
 - A substantive change in the composition of the *group*; or
 - Fraud or misrepresentation of a material fact by the *group plan sponsor*, *employee* or an *employee's dependent*; or
- The *group plan sponsor* changes the terms of this *master group contract* with *our* written or *electronically* transmitted consent; or
- *We* provide 60 days written or *electronic* notice to the *group plan sponsor* that the premium rates will change, as permitted by applicable law. Such notice shall include the effective date of the change in premium rates.

PREMIUMS (continued)

Premium charges for benefit changes or a modification of a covered person's coverage

If the *group* health plan benefits or a *covered person's* coverage are modified other than on a premium due date, any applicable change in premium resulting from the modification will become effective as follows:

For a *group* with 1-100 *employees*, the change in premium will be effective on the date the change in coverage becomes effective.

For a *group* with 101 or more *employees*:

- If the change is effective on or before the 15th of the month, the change in premium will be effective on the first of the month during which the change in coverage is effective;
- If the change is effective after the 15th of the month, the change in premium will be effective on the first of the month following the effective date of the change in coverage.

The effective date of a change in premium will only vary from the above upon mutual written agreement between the *group plan sponsor* and *us*.

Notice of covered person coverage terminations

Notice of any *covered person's* coverage termination should be given to us within 31 days of the termination date. An individual remains a *covered person* under the *master group contract* until the *group plan sponsor* notifies *us* the individual is no longer eligible for coverage. Failure to notify *us* of a individual's termination of coverage within 31 days will result in the *group plan sponsor* being liable for the *covered person's* premium from the time the individual is no longer eligible for coverage under the *master group contract* until the end of the month in which the *group plan sponsor* notifies *us* of the *covered person's* coverage termination.

Grace period

While this *master group contract* continues in force, a grace period of 31 days will be allowed to the *group plan sponsor* following the premium due date, for the payment of each required premium due. This *master group contract* will remain in force during the grace period. If the required premium is not paid by the end of the 31-day grace period, this *master group contract* will terminate effective as of the last day of the month for which the last premium was received. Any claims incurred after the last day of the month for which premium was received are the responsibility of the *group plan sponsor*.

PREMIUMS (continued)

Unpaid premium

If the required premium is not paid by the end of the 31-day grace period, *we* will collect the premium for the grace period.

Unpaid premium is subject to a late charge for each late month beginning on the first day after the premium due date. The late charge will be based on:

- A flat fee determined by *group* enrollment count; or
- 1.5% of premium per month.
- If the required premium is not paid by the end of the 31-day grace period, *we* will collect the premium for the grace period.

Wellness Engagement Incentive Program Amendment

This "Wellness Engagement Incentive Program Amendment" (amendment) is made part of the *master group contract* to which it is attached.

Notwithstanding any other provisions of the *master group contract*, incentives or rewards provided under this amendment are not duplicated under any other provision of the *master group contract*. This amendment does not change any other terms or conditions of the *master group contract*.

All defined terms used in this amendment have the same meaning given to them in the *evidence of coverage* unless otherwise specifically defined in this amendment.

Payment of premium on or after the effective date of this amendment will be deemed to constitute the *group plan sponsor's* agreement to the terms of this amendment.

This amendment modifies the "Premium" section of the *master group contract* by adding the following:

Wellness engagement incentive program

A wellness engagement incentive up to 10% may be credited for participation by *employees* in the wellness rewards program, made available with this *master group contract*. The incentive will be credited to the premium statement, or issued separately to the *policyholder*, for each *employee* covered under the *master group contract* who has achieved the engaged status as defined in the wellness rewards program, as of the last day of the preceding calendar month.

For *employees* covered under the *master group contract* as of the last day of the preceding calendar month, we will also consider the three preceding calendar months when the incentive is calculated to ensure *employees* that were not included in prior calculations due to certain delays in submitting information to *our* wellness program administrator are included if they attained the engaged status, as defined in the wellness rewards program.

It is the *employer's* responsibility to determine how the incentive will be used in accordance with applicable federal and state law, including but not limited to:

- The Federal Employee Retirement Income Security Act of 1974 (ERISA), as amended;
- The Patient Protection and Affordable Care Act (the Affordable Care Act), as amended;
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended;
- The Civil Rights Act of 1964, as amended;
- The Americans with Disabilities Act of 1990 (ADA), as amended;
- The Age Discrimination in Employment Act of 1967 (ADEA), as amended; and
- The Genetic Information Nondiscrimination Act of 2008 (GINA), as amended.

Wellness Engagement Incentive Program Amendment (continued)

Employers should check with their tax and legal counsel to establish appropriate uses for the incentives. For example, if a *group* health plan is subject to ERISA, the *employer* or the administrator of the *group* health plan may have fiduciary responsibilities regarding use of the incentives. Some or all of the incentives may be considered funds attributable to plan assets, which generally must be used for the exclusive benefit of the *group* health plan participants. *We* are not liable for monetary penalties or fines, or other state or federal regulatory action taken against the *employer* for failure to comply with any applicable federal or state law.

No wellness engagement incentive will be earned:

- After the *master group contract* terminates; or
- During the last calendar month of coverage.

Humana Health Plan of Texas, Inc.



Bruce Broussard
President



Administrative Office:
1100 Employers Boulevard
DePere, Wisconsin 54115

Humana Insurance Company

Policyholder: V&L MANAGEMENT

Policy Number: 736995

Effective Date of Policy: 12/01/2016

Product Name: TXFF0003 COIN

Terms printed in italic type in this *policy* have the meaning as indicated in the "Glossary" and "Glossary – Pharmacy Services" sections of the *certificate*. Defined terms are printed in italic type whenever found in this *policy*.

This *policy* is delivered in and governed by the laws of: TEXAS.

Humana Insurance Company agrees, subject to all the terms and provisions of this *policy*, to pay benefits as described in the Certificate of Insurance, incorporated by reference herein, with respect to each *covered person* under this *policy*. Humana Insurance Company and the *policyholder* have agreed to all of the terms of this *policy*.

This *policy* is a companion plan to the Master Group Contract issued to the *policyholder* by Humana Health Plan of Texas, Inc. (the *HMO*).

The *policy* is issued in consideration of the *policyholder's* application, incorporated by reference herein, and such *policyholder's* payment of premiums as provided under this *policy*.

This *policy* and the insurance it provides become effective at 12:01 A.M. (Standard Time) of the effective date stated above. This *policy* and the insurance it provides terminates at 12:00 A.M. (Standard Time) of the date of termination. The provisions stated above and on the following pages are parts of this *policy*.

A handwritten signature in black ink, appearing to read "Bruce Broussard".

Bruce Broussard
President

THIS CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLAN, EITHER IN WHOLE OR IN PART, DOES NOT PROVIDE STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. THIS STANDARD HEALTH BENEFIT PLAN MAY PROVIDE A MORE AFFORDABLE HEALTH INSURANCE POLICY FOR YOU ALTHOUGH, AT THE SAME TIME, IT MAY PROVIDE YOU WITH FEWER HEALTH BENEFITS THAN THOSE NORMALLY INCLUDED AS STATE-MANDATED HEALTH BENEFITS IN POLICIES IN TEXAS. PLEASE CONSULT WITH YOUR INSURANCE AGENT TO DISCOVER WHICH STATE-MANDATED HEALTH BENEFITS ARE EXCLUDED IN THIS POLICY.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE AND DOES NOT REPLACE WORKERS' COMPENSATION INSURANCE. THE *EMPLOYER* DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS *POLICY*, AND IF THE *EMPLOYER* IS A NON-SUBSCRIBER, THE *EMPLOYER* LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE *EMPLOYER* MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This is not a policy of Long Term Care insurance.
100300TX 01/16 (2)

1. IMPORTANT NOTICE

To obtain information or make a complaint:

2. You may call Humana Insurance Company's toll-free telephone number for information or to make a complaint at:

1-866-4ASSIST

3. You may also write to Humana Insurance Company at:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

5. You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

6. PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

7. ATTACH THIS NOTICE TO YOUR

POLICY: This notice is for information only and does not become a part or condition of the attached document.

100350TX 01/16 (2)

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Humana Insurance Company's para obtener información o para presentar una queja al:

1-866-4ASSIST

Usted también puede escribir a Humana Insurance Company:

Green Bay Service Center
(Badger/MTV Medical)
P.O. Box 14618
Lexington, KY 40512-4618

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 490-1007
Sitio web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

SUBSIDIARIES OR AFFILIATES

Any *employer*, which is a subsidiary or affiliate of a *policyholder* is eligible under the *policyholder's* group health plan provided under this *policy* if the following conditions are met:

- The subsidiary or affiliate is a company owned and controlled by the *policyholder*, files a combined tax return and is listed in the Employer Group Application of the *policyholder*, or in any amendment thereto;
- The *policyholder* and the subsidiary or affiliate are members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code; and
- The subsidiary or affiliate has been approved for coverage under this *policy*, in writing or by *electronic mail*, by both the *policyholder* and *us*.

For the purposes of this *policy*, an *employee* of such a subsidiary or affiliate of the *policyholder* shall be considered to be an *employee* of the *policyholder*.

A subsidiary or affiliate of a *policyholder* shall cease to be eligible in the *policyholder's* group health plan provided under this *policy* on the earliest of the following:

- The date the *policyholder* and the subsidiary or affiliate are no longer members of the same controlled group of corporations, trades or business under common control, as described for employee benefits taxation purposes in the Internal Revenue Code;
- The date the *policyholder's* written notice of its intent to terminate the participation of the subsidiary or affiliate is received by *us*, or on any later date as may be stated in such notice; or
- The date this *policy* terminates.

The insurance of any *employee* of a subsidiary or affiliate of a *policyholder*, and the insurance of such *employee's* covered *dependents*, shall immediately terminate on the date the subsidiary or affiliate ceases participation in the *policyholder's* group health plan.

100500TX 01/16

REQUIREMENTS FOR INSURANCE COVERAGE

Point of service - eligibility and enrollment

To be eligible to enroll for the coverage provided through this *policy*, the *employee* and his or her *dependents* must meet the eligibility requirements of the *HMO* and be enrolled in the *HMO*.

101150TX 01/16

PARTICIPATION REQUIREMENTS

The *policyholder* must maintain *our* minimum participation and contribution requirements, as specified in the underwriting requirements of the Employer Group Application.

101200TX 01/16

RENEWAL AND TERMINATION PRIVILEGE

Point of service – renewal and termination

The *policy* will continue in force as long as the *policyholder* participates in the *health insurance coverage* offered under the *policy* and the health coverage of the *HMO* master group contract. If the *policyholder* terminates participation in the *HMO* master group contract, insurance coverage provided through the *policy* will simultaneously be terminated. We may terminate the health coverage as described in the "Renewal and Termination Privilege" section of the *HMO* master group contract.

102110TX 01/16

PREMIUMS

Payment of premiums

Unless otherwise agreed to by *us*, the first premium is due on the *policyholder's* effective date under this *policy*. Subsequent premiums are due on the first of each calendar month thereafter.

Premiums should be sent to the designated location on the premium statement. Premiums will be recorded as paid on the date *we* receive the payment.

Premium statement

A premium statement will be prepared in accordance with the billing method *we* arrange with the *policyholder*. This premium statement will show the premium due. It will also reflect any pro rata premium charges and credits resulting from changes in the number of *covered persons* and changes in the amounts of insurance that took place during the period following the last premium statement. In the event that notice of termination of coverage, or a decrease in coverage, for a *covered person* is received by *us* more than one month after the termination of coverage or decrease in coverage, retroactive premium credit will not be permitted. The *policyholder* is liable for premiums on the *covered person* from the time the *covered person* is no longer eligible for coverage under this *policy* until the end of the month in which *we* are notified by the *policyholder* that the *covered person* is no longer eligible for coverage under this *policy*. The individual remains a *covered person* under this *policy* until the end of that period.

Premium rate change

As permitted by applicable law, *we* reserve the right to change any premium rate by giving written notice to the *policyholder* no less than 60 days prior to the effective date of the change when:

- The terms of the *policy* are changed by *us*; or
- *Our* liability has been altered, in *our* opinion, because of a change in state or federal law.

As permitted by applicable law, *we* reserve the right to retroactively change the premium rate when:

- *Our* liability has been altered, in *our* opinion because of:
 - A substantive change in the composition of the *group*; or
 - Fraud or misrepresentation of a material fact by the *policyholder*, the *employee*, or an *employee's dependent*; or
- The *policyholder* changes the terms of this *policy* with *our* written or *electronically* transmitted consent.

PREMIUMS (continued)

Premium charges for benefit changes or a modification of a covered person's coverage

If the *group* health plan benefits or a *covered person's* insurance coverage are modified other than on a premium due date, any applicable change in premium resulting from the modification will become effective as follows:

For a *group* with 1-100 *employees*, the change in premium will be effective on the date the change in coverage becomes effective.

For a *group* with 101 or more *employees*:

- If the change is effective on or before the 15th of the month, the change in premium will be effective on the first of the month during which the change in coverage is effective;
- If the change is effective after the 15th of the month, the change in premium will be effective on the first of the month following the effective date of the change in coverage.

The effective date of a change in premium will only vary from the above upon mutual written agreement between the *policyholder* and *us*.

Notice of covered person coverage terminations

The *policyholder* is liable for a *covered persons* premiums from the time the individual is no longer eligible for coverage under this *policy* until the end of the month in which the *policyholder* notifies *us* that the individual is no longer eligible for coverage under this *policy*. The individual remains a *covered person* under this *policy* until the end of that period.

Grace period

While this *policy* continues in force, a grace period of 31 days will be allowed to the *policyholder* following the premium due date, for the payment of each required premium due. This *policy* will remain in force during the grace period. If the required premium is not paid by the end of the 31 day grace period, this *policy* will terminate. The *policyholder* will be required to pay premium for the grace period.

Unpaid premium

If the required premium is not paid by the end of the 31-day grace period, *we* will collect the premium for the grace period.

103000TX 01/16

Wellness Engagement Incentive Program Amendment

This "Wellness Engagement Incentive Program Amendment" (amendment) is made part of the *policy* to which it is attached.

Notwithstanding any other provisions of the *policy*, incentives or rewards provided under this amendment are not duplicated under any other provision of the *policy*. This amendment does not change any other terms or conditions of the *policy*.

All defined terms used in this amendment have the same meaning given to them in the *certificate* unless otherwise specifically defined in this amendment.

Payment of premium on or after the effective date of this amendment will be deemed to constitute the *policyholder's* agreement to the terms of this amendment.

This amendment modifies the "Premium" section of the *policy* by adding the following:

Wellness engagement incentive program

A wellness engagement incentive up to 10% may be credited for participation by *employees* in the wellness rewards program, made available with this *policy*. The incentive will be credited to the premium statement, or issued separately to the *policyholder*, for each *employee* covered under the *policy* who has achieved the engaged status, as defined in the wellness rewards program, as of the last day of the preceding calendar month.

For *employees* covered under the *policy* as of the last day of the preceding calendar month, *we* will also consider the three preceding calendar months when the incentive is calculated to ensure *employees* that were not included in prior calculations due to certain delays in submitting information to *our* wellness program administrator are included if they attained the engaged status, as defined in the wellness rewards program.

It is the *employer's* responsibility to determine how the incentive will be used in accordance with applicable federal and state law, including but not limited to:

- The Federal Employee Retirement Income Security Act of 1974 (ERISA), as amended;
- The Patient Protection and Affordable Care Act (the Affordable Care Act), as amended;
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended;
- The Civil Rights Act of 1964, as amended;
- The Americans with Disabilities Act of 1990 (ADA), as amended;
- The Age Discrimination in Employment Act of 1967 (ADEA), as amended; and
- The Genetic Information Nondiscrimination Act of 2008 (GINA), as amended.

Wellness Engagement Incentive Program Amendment (continued)

Employers should check with their tax and legal counsel to establish appropriate uses for the incentives. For example, if a *group* health plan is subject to ERISA, the *employer* or the administrator of the *group* health plan may have fiduciary responsibilities regarding use of the incentives. Some or all of the incentives may be considered funds attributable to plan assets, which generally must be used for the exclusive benefit of the *group* health plan participants. *We* are not liable for monetary penalties or fines, or other state or federal regulatory action taken against the *employer* for failure to comply with any applicable federal or state law.

No wellness engagement incentive will be earned:

- After the *policy* terminates; or
- During the last calendar month of coverage.

Humana Insurance Company

A handwritten signature in black ink, appearing to read "Bruce Broussard". The signature is fluid and cursive, with the first name "Bruce" and last name "Broussard" clearly distinguishable.

Bruce Broussard
President

PREMIUMS (continued)
