Keep your eyes healthy with a HumanaVision plan

For the employees/retirees of the Town of Lynnfield

Eye examinations not only help your vision, but your doctor can catch major health issues too. Many diseases – diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis – can be diagnosed by looking into your eyes.

A HumanaVision Care Plan encourages prevention, early diagnosis, and treatment – helping you achieve good vision and a healthy lifestyle.

Here are a few more reasons to choose HumanaVision:

- You'll receive wholesale prices on frames
- Choose from more than 35,000 participating optometrist, ophthalmologist, and national retail locations, including LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney.
- You can receive discounts on Lasik procedures
- You can view benefits, check eligibility, find providers, and use other automated services at **HumanaVisionCare.com**

A HUMANA REPRESENTATIVE WILL HOLD A GROUP MEETING ON TUESDAY, APRIL 10TH FROM 11:00 AM - 4:00 PM.

Town of Lynnfield monthly rates

Employee	$7.83
Employee and spouse	$15.66
Employee and children	$14.87
Family	$23.37

Vision products insured by Humana Insurance Company or Humana Insurance Company of Kentucky or Humana Health Benefit Plan of Louisiana, Inc.

HUMANA®

HumanaVision

HUMANA

Vision Care Plan

Town of Lynnfield

	See a participating provider	See a nonparticipating provider
Exam with dilation as necessary	100% after $20 copay	$35 allowance
Lenses		
• Single	100% after $20 copay	$25 allowance
• Bifocal	100% after $20 copay	$40 allowance
• Trifocal	100% after $20 copay	$60 allowance
Frames	$45 wholesale allowance	$40 retail allowance
Contact lenses[1]		
• Elective (conventional and disposable)[2 3]	$110 allowance	$110 allowance
• Medically necessary	100%	$210 allowance
Frequency (based on date of service)		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months

Additional plan discounts

- Members receive additional fixed copayments on lens options including: anti-reflective and scratch-resistant coatings.
- 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 copay, standard polycarbonate available at no charge for dependents less than 19 years old.

[1] If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames) (Vision Care Plan only).

[2] The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members receive a 15 percent discount on in-network professional services. The discount for professional services is available for 12 months after the covered eye exam.

[3] Contact lens allowance must be used at one time; no amount will be carried forward.

HumanaVision Lasik discount

We have contracted with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

	Conventional / Traditional		Custom	
TLC 888-358-3937 (designated locations only)	**$895**		**$1,295**	**$1,895***
Lasik*Plus* 866-757-8082	**$695*** Lasik*Plus* free enhancements for 1 year	**$1,395*** Lasik*Plus* free enhancements for life	**$1,895*** Lasik*Plus* free enhancements for life	
QualSight LASIK 855-456-2020	**$895** QualSight free enhancements for 1 year	**$1,295** with QualSight Lifetime Assurance Plan	**$1,320**	**$1,995*** with QualSight Lifetime Assurance Plan

*with IntraLase™

You can also use independent Lasik provider network doctors to receive a 10% discount from usual and customary prices and pay no more than $1,800 per eye for Conventional Lasik and $2,300 per eye for Custom Lasik.

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.

Retail price*	Wholesale price	Wholesale allowance	Member pays	Savings
$125	$50	$50	$0	$125
$187.50	$75	$50	$50 ($75-$50=$25x2=$50)	$137.50

* Retail costs may differ and are based on 2½ times the wholesale cost. Actual savings may vary.

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]

Use your HumanaVision benefits

HumanaVision 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 35,000 participating optometrist, ophthalmologists, and national retail locations, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical. 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 your vision plan, you 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's 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 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 and national retail locations.
- 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, 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 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

Private Practitioners · LensCrafters · Pearle Vision · JCPenney Optical · Sears Optical · Target Optical

HUMANA®

Insured by Humana Insurance Company, HumanaDental Insurance Company, CompBenefits Insurance Company, or The Dental Concern, Inc.

[1] Thompson Media Inc.

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-C 4/11

Print Form

Visit us at www.humana.com or www.humanadental.com

Humana Employee Enrollment Application - Vision MASSACHUSETTS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

Vision plans insured and administered by Humana Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: __ / __ / ____

Company name: Town of Lynnfield | Company city: Lynnfield | State: MA

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason.
Employee		/		F M	N/A	__/__/____	N Y Reason:
Spouse		/		F M	N/A	__/__/____	N Y Reason:
Child		/		F M	N Y	__/__/____	N Y Reason:
Child		/		F M	N Y	__/__/____	N Y Reason:
Child		/		F M	N Y	__/__/____	N Y Reason:
Other (specify):		/		F M	N Y	__/__/____	N Y Reason:

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ☐ **RETIREE** **DATE OF FULL-TIME HIRE:** __ / __ / ____

SSN # | Street address | APT / Suite / Box

City | State | Zip code | Phone # ( )

Language: ❍ English ❍ Spanish | Email address

Dental

Group #: | Benefit #: | Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver) | Plan name

Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y

Prior dental insurance carrier name | **Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family | Effective date __ / __ / ____ | Policy #

Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y | Term date __ / __ / ____ | Prior carrier phone # ( )

Vision

Group #: 614628 | Benefit #: None | Class/Div: 02

Coverage type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family ☐ NO COVERAGE (complete waiver) | 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 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:

Last name: | First name:

Notice of Information Practices

Humana may collect personal information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates or others. We may share personal or privileged information with affiliated companies and non-affiliated third parties without authorization, as permitted by law. You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. A complete notice of our privacy practices can be obtained by contacting us at 1-866-861-2762 or by visiting our website at www.humana.com and going to the privacy practices link.

Disclosures (applicable to dental and vision plans)

Pre-existing conditions are not excluded. Benefits listed in the policy/certificate ARE NOT contingent upon hospital confinement. Coverage for You and/or Your Dependent may be canceled or its renewal refused because of:

1. failure to pay the required premium;
2. misrepresentation or fraud on the part of the member;
3. commission of acts of physical or verbal abuse by the member which pose a threat to providers or other members and which are unrelated to the physical or mental condition of the member; or
4. non-renewal or cancellation of the Policy through which the member receives services.

If Your coverage ends because of (1) above, We will send written notice of the termination to You prior to the date covered services were received. The written notice will contain the following information:

1. the date on which the plan was terminated;
2. that the termination was for failure to pay the required premium; and
3. that We will honor claims, to the extent covered under the Policy, for any covered service received by You or Your Dependent prior to the notification date.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

I acknowledge that I have read and understand the above disclosures.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document 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 within 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 deny life or dental coverage with any future application for coverage.
- 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.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)