Humana Vision 130

WISCONSIN

Housing Authority of City of Milwaukee

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$130 allowance 20% off balance over $130	$65 allowance
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

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Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• 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
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

[3] Discounts may be available on all frames except when prohibited by the manufacturer.

[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

[5] Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Employee and Individual Application and Enrollment Form - WISCONSIN

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Employee and Individual Application and Enrollment Form as "Humana". To elect primary care physician please complete reorder WI-51340-PP.

Medical HMO plans offered by Humana Wisconsin Health Organization Insurance Corporation. Humana National POS Medical POS plans offered by Humana Wisconsin Health Organization Insurance Corporation and insured or administered by Humana Insurance Company. PPO and Indemnity Medical plans, Life and Vision plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or by Humana Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits plans insured or administered by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: 05 / 01 / 2017

Employer / Group name	Employer / Group city	State
Housing Authority of the City of Milwaukee		

Qualifying Event Instructions Date of Qualifying Event: __ / __ / ____

- ❍ New business enrollment
- ❍ New hire / Newly eligible
- ❍ Open Enrollment event
- ❍ Rehire / Reinstatement
- ❍ Dependent birth or adoption
- ❍ Marital status change
- ❍ Loss of coverage
- ❍ Other_____

Enrollment information

Relationship	Last name, First name MI	Gender	Date of birth	Disabled? If yes, indicate reason below.	Social Security Number
Employee / Individual		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	
Child / Dependent		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	
Child / Dependent		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	
Child / Dependent		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	
Other (specify):		❍ F ❍ M	__ / __ / ____	❍ Y ❍ N	

Employee / Individual Information

Hours worked per week:		Date of full time hire: __ / __ / ____	
Social Security Number	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation	
Are you actively at work? ❍ Y ❍ N If not, reason: ❍ Retiree ❍ COBRA Other: _____			Annual salary $

Vision

Group #: Benefit #: Class/Div:

Coverage type:
- ❍ Employee / Individual only
- ❍ Employee / Individual and spouse
- ❍ Employee / Individual and child(ren)
- ❍ Family
- ❍ No Coverage (complete waiver)

Plan name:

- Any person who willingly and knowingly submits the Small Group Employee and Individual Application and Enrollment Form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

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 the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

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 / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.