ASSOCIATED CREDIT UNION

Enrollment Instructions

- Complete the application. (Be sure to list all Family Members to be included).
- Return the completed application by the 15th of the month to become effective by the 1st of the following month. Deductions from you account will be made in accordance with the procedures established and communicated by Humana.
- **Email Applications to: acu@aalarocco.com.** or **fax to (770) 729-9966**
- **Telephone Inquiries: 678-325-4645**

Please complete the following information:			
Social Security #	Last Name	First	Birth Date
Home Phone	Home Address	City, State, Zip	Sex M ☐ F ☐

List All of your eligible dependents that are to be covered:			
First / Last		Sex	Birth Date
Member:		M ☐ F ☐	/ /
Spouse:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /

Effective Date:	Group Number 785517	Premium Amount	Amount Paid	Agent Code **0204222GA**

PLEASE CHECK YOUR CHOICE	☐ **New PPO Dental Plan 100/80/50 U&C**	☐ **Dental Plan C150 GA DHMO**	☐ **Vision Plan Humana Vision 130**
Monthly Rates			
Member Only	☐ **$41.39**	☐ **$17.88**	☐ **$8.64**
Member + One	**N/A**	☐ **$32.66**	**N/A**
Member + Spouse	☐ **$82.79**	**N/A**	☐ **$17.26**
Member + Child(ren)	☐ **$105.56**	**N/A**	☐ **$16.38**
Member + Family	☐ **$147.95**	☐ **$46.96**	☐ **$26.94**

Authorization for Deduction — Signature required — Automatic deduction is the only option for payment

Name _____
(Last) (First) (MI)

Social Security No._____

I authori ASSOCIATED CREDIT UNION _____
(Employer, Financial, or other organization)

To make a monthly deduction of $_____from: My Checking, Savings Account No._____
check one: ( ) checking ( ) savings

I hereby authorize CompBenefits to deduct monthly and future renewal period(s) my portion of such subscription fee from any funds due me. I understand that enrollments are by group contract and/or my subscription fee is subject to change on the anniversary/renewal date of the Group. I hereby represent to the carrier that all information furnished by me hereon is true and complete to the best of my knowledge. I hereby consent, personally and on behalf of any family member enrolled, to the unrestricted release of my/our vision records maintained by participating vision providers to CompBenefits for, but no limited to, verification and quality assessment review, and to any other participating vision provider who may be or become involved in my/our vision care.

Date_____20 _____Signature X _____

ASSOCIATED CREDIT UNION

Humana Dental and Vision

TO LOCATE A HUMANA IN NETWORK DENTAL OR VISION PROVIDER, GO TO:

www.humana.com

Click on FIND CARE under the sign in button in the upper righthand corner
Click on **Browse as a Guest**

TO FIND A DENTAL PROVIDER, CLICK ON DENTAL:

Enter your zip code and distance
CLICK on Coverage Type:

If you are electing the PPO dental product, click select a network:
PPO/Traditional Preferred

If you are electing the DHMO dental product, click select a network:
HD DHMO/Prepaid C150

You can narrow down your search by entering
Distance/Search Category/Dentist name or specialty

TO FIND A VISION PROVIDER, CLICK ON VISION:

CLICK on I'm just browsing, hit continue
Under Shopping for a Vision plan, scroll to Coverage through an Employer

CLICK on Humana Vision (Humana Insight Network)

Select your search method
If you are searching by location, enter the information requested
If you are search by doctor, enter the name of the doctor

IF YOU WISH TO ENROLL IN THE DENTAL AND/OR VISION PLAN(S) OFFERED, PLEASE COMPLETE THE APPLICATION AND RETURN TO:

Email: ACU@aalarocco.com **or**

FAX: **(770) 729-9966**

For more Information, please call (678) 325-4645

Humana Dental Traditional Preferred

GEORGIA

GA TRP U&C+ 100/80/50
Associated Credit Union
Network: PPO/Traditional Preferred

Services	In-network dentist	Out-of-network dentist U&C 90
Deductible (excludes orthodontia services)	Individual: $50 Family: $150	Individual: $50 Family: $150
	Deductible applies to all services excluding preventive services.	
Annual maximum (excludes orthodontia services)	$1,500 + extended annual maximum (see section below)	
Preventive services **Routine oral examinations** (3 per year) **Bitewing x-rays** (2 films under age 10, up to 4 films ages 10 and older) **Panoramic x-rays** (1 per 5 years combined, Panorex and Full Mouth X-rays share the same frequency; ages 6+) **Routine cleanings** (3 per year) **Periodontal cleanings** (4 per year) **Fluoride treatment** (1 per year, through age 16) **Sealants** (permanent molars, through age 16) **Space maintainers** (primary teeth, through age 15) **Oral Cancer Screening** (1 per year, ages 40 and older)	100% no deductible	100% no deductible
Basic services **Emergency care for pain relief** **Amalgam fillings** (1 per tooth every 2 years, composite for anterior/front teeth) **Composite fillings** (1 per tooth every 2 years, molar teeth) **Oral surgery** (including extractions of impacted teeth) **General anesthesia**[1] **Stainless steel crowns** **Harmful habit appliances for children** (1 per lifetime, through age 14)	80% after deductible	80% after deductible

[1] Only covered in conjunction with covered oral surgical procedures. Other restrictions may apply.

Humana Dental Traditional Preferred

GA TRP U&C+ 100/80/50

Associated Credit Union

GEORGIA

Services	In-network dentist	Out-of-network dentist U&C 90
Major services **Crowns** (1 per tooth every 5 years) **Inlays/onlays** (1 per tooth every 5 years) **Bridges** (1 every 5 years) **Dentures** (1 every 5 years) **Denture relines/rebases** (1 every 3 years, following 6 months of denture use) **Denture repair and adjustments** (following 6 months of denture use) **Implants** (crowns, bridges, and dentures each limited to 1 per tooth every five years) **Periodontics** (scaling/root planing and surgery 1 per quadrant every 3 years) **Endodontics** (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible	50% after deductible
Extended Annual Max Additional coverage for preventive, basic, and major services after the annual maximum is met (excludes orthodontia)	30%	30%
Orthodontia services	Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.	

Humana will reimburse out-of-network claims based on internal and external data (including FairHealth industry benchmarks) to establish reimbursement limits by geographic region. Out of network dentists may bill members for charges above the amount covered by the dental plan.

Questions?

Call (678) 325-4645

Register today!

Register or sign in to MyHumana at **Humana.com** to view your coverage details, ID cards, manage claims, find a dentist and more!

Limitations and exclusions (all services):
In addition to the limitations and exclusions listed in **Your plan benefits section**, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   - Any service to correct congenital malformation;
   - Any service performed primarily to improve appearance;
   - Characterizations and personalization of prosthetic devices; or
   - Any procedure to change the spacing and/or shape of the teeth
7. Charges for:
   - Any type of implant and all related services;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments;
   - Any service for 3D imaging (cone beam images);
   - Temporary and interim dental services;
   - Additional charges related to material or equipment used in the delivery of dental care.
   - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer policyholder;
   - The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
   - Altering vertical dimension of teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
   - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
    - Is not eligible for benefits based upon clinical review;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional acceptance; or
    - Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

- continued on next page

Extended annual maximum

Unique solution for extended coverage

With Humana's extended annual maximum, employees won't have to put off important dental care procedures for themselves or their covered dependents.

Extended annual maximum is available immediately after the annual maximum for a plan is reached, and there's no cap on the dollars paid in a year. That's an attractive advantage over traditional rollover options.

Extended annual maximum helps employees save money by ensuring they have access to network discounts and 30% coinsurance, even after they have reached their annual maximum. Employees can achieve and maintain their best health by getting dental care when it's needed, before oral health issues may affect their overall health and well-being.

Plus, the extended annual maximum is a great way for groups and employees to buy down their annual maximum or coinsurance, or adjust plan deductibles and their out-of-network reimbursements.

QUESTIONS:

Call (678) 325-4645

Uniquely different from traditional rollover plans

- No need to delay care
- No paid claims thresholds
- No dollars to roll over
- No provider restrictions
- No mandatory claims submissions
- No need to track annual usage

Extended annual maximum advantages

- **Simple** – all employees and their dependents have the same benefits
- **Easy** – the plan is easy to describe and administer
- **Immediate** – employees can use the benefit beginning day one
- **Available** – included in all Traditional Preferred (Plus) and PPO plan groups of two or more

Humana®

HumanaDental Prepaid 150 C Plan

NETWORK: HD DHMO/PREPAID C 150

Use your HumanaDental benefits

The HumanaDental C Series dental plan has you covered for any circumstance. Whether you simply need quality routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

Know what your plan covers

Attached is a summary of HumanaDental C Series plan benefits which are described in detail in your certificate. You can find your certificate at **Humana.com** or call 1-800-979-4760. Here's what you can expect:

- You have the freedom to select any participating general dentist. To select a dental provider from our network, simply visit **Humana.com**. Once there, you can also check your benefits, email us and get a new or temporary ID card. If you prefer, contact us at 1-800-979-4760.
- Life without claim forms! With HumanaDental Prepaid plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and any copayment or discounted charges will be paid at the time of service.
- If you need a specialty dentist, you may receive a 25 percent discount by using one of the participating specialty dentists from our network. Visit **Humana.com** to find a participating specialist.

Choose HumanaDental benefits

Be healthy

Good oral health means more than just an attractive smile. Research shows that oral health, preventive care and regular visits to the dentist is integral to overall health. For example, the Academy of General Dentistry says there is a link between gum disease and heart problems, and the American Academy of Periodontology says severe gum disease can increase blood sugar, increasing the risk among diabetics. The HumanaDental Prepaid plan enables you to take better care of your teeth, and you'll pay less doing so.

Check your dental IQ anytime

Log on to **MyDentalIQ.com** and take the dental risk assessment that could help trim your total healthcare costs over time. Find out how you can improve your oral and overall health. The dental health risk assessment at **MyDentalIQ.com** takes minutes to complete, and immediately delivers a scorecard with health tips tailored to you.

Questions?

Call (678) 325-4645

HumanaDental Prepaid 150 C Plan

NETWORK: HD DHMO/PREPAID C 150

The HumanaDental Prepaid plans focus on maintaining oral health, prevention and cost-containment. A member may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. C plans copayments for listed procedures are applicable only at a participating general dentist.

Member costs listed here are for services provided by your chosen participating primary care dentist (PCD) only. A PCD may decide that you need to see a participating specialist. No referral is necessary to see a participating specialist.

Specialists services: Should you need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), you may be referred by your participating general dentist, or you may refer yourself to any participating specialist. For C plans and benefits for procedures not listed on the schedule, you may receive up to a 25 percent discount by visiting a participating specialist.

Summary of services

Appointments		**Member pays**
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$ 15.00
D9430	Office visit (normal hours)	$ 5.00
D9440	Office visit (after regularly scheduled hours)	$ 35.00
D9999	Emergency visit during regularly scheduled hours, by report.	$ 20.00
D9999	Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies.	$ 10.00

Diagnostic		**Member pays**
D0120	Periodic oral examination	no charge
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge
D0150	Limited/comprehensive/detailed and extensive oral eval	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge
D0180	Comprehensive periodontal evaluation.	$ 10.00
D0210	X-ray intraoral—complete series including bitewings	no charge
D0220	X-ray intraoral—periapical, first radiographic image	no charge
D0230	X-ray intraoral—periapical, each additional radiographic image	no charge
D0270	X-ray bitewing—single radiographic image	no charge
D0272	X-ray bitewings—two radiographic images	no charge
D0274	Bitewings—four radiographic images	no charge
D0330	Panoramic radiographic image	no charge
D0460	Pulp vitality tests	no charge
D0470	Diagnostic casts	no charge

Preventive		**Member pays**
D1110	Prophylaxis—adult, routine (once every 6 months)	no charge
D1120	Prophylaxis—child, routine (once every 6 months)	no charge
D1110	Prophylaxis—adult/child, (additional)	$ 20.00
D1120	Prophylaxis—adult/child, (additional)	$ 20.00
D1201	Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	no charge
D1203	Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	no charge
D1330	Oral hygiene instruction	no charge
D1351	Sealant-per tooth	$ 10.00
D1510	Space maintainer—fixed, unilateral	$ 45.00+lab
D1515	Space maintainer—fixed, bilateral	$ 45.00+lab
D1520	Space maintainer—removable, unilateral	$ 85.00+lab
D1525	Space maintainer—removable, bilateral	$ 85.00+lab
D1550	Recementation of space maintainer	$ 10.00

Restorative		**Member pays**
D2140	Amalgam—one surface, primary or permanent	no charge
D2150	Amalgam—two surfaces, primary or permanent	no charge
D2160	Amalgam—three surfaces, primary or permanent	no charge
D2161	Amalgam—four or more surfaces, primary or permanent	no charge
D2940	Sedative filling	$ 15.00
D2999	Sedative base (under fillings), by report	no charge

Resin restorative		**Member pays**
D2330	Resin based composite—one surface, anterior	$ 35.00
D2331	Resin based composite—two surfaces, anterior	$ 40.00
D2332	Resin based composite—three surfaces, anterior	$ 50.00
D2391	Resin based composite—one surface, posterior	$ 60.00
D2392	Resin based composite—two surfaces, posterior	$ 80.00
D2393	Resin based composite—three surfaces, posterior	$ 100.00
D2394	Resin based composite—four or more surfaces, posterior	$ 120.00
D2510	Inlay—metallic, one surface	$ 95.00
D2520	Inlay—metallic, two surfaces	$ 105.00
D2530	Inlay—metallic, three or more surfaces	$ 130.00

Crown and bridge		**Member pays**
D2740	Crown—porcelain/ceramic	$ 280.00+lab
D2750*	Crown—porcelain fused to high noble metal	$ 280.00
D2751	Crown—porcelain fused to predominantly base metal	$ 280.00
D2752*	Crown—porcelain fused to noble metal	$ 280.00
D2790*	Crown—full cast high noble metal	$ 280.00
D2791	Crown—full cast predominantly base metal	$ 280.00
D2792*	Crown—full cast noble metal	$ 280.00
D2910	Recement inlay	$ 15.00

D2920	Recement crown	$ 15.00
D2930	Prefabricated stainless steel crown—primary tooth	$ 75.00
D2950	Core buildup, including any pins	$ 45.00
D2951	Pin retention—per tooth	$ 15.00
D2952	Cast post and core in addition to crown	$ 90.00+lab
D2953	Each additional cast post—same tooth	$ 90.00+lab
D2954	Prefabricated post and core in addition to crown	$ 90.00
D2962	Labial veneer (porcelain laminate)—laboratory	$280.00+lab

Prosthodontics (fixed)		Member pays
D6210*	Pontic—cast high noble metal	$ 280.00
D6211	Pontic—cast predominantly base metal	$ 280.00
D6212*	Pontic—cast noble metal	$ 280.00
D6240*	Pontic—porcelain fused to high noble metal	$ 280.00
D6241	Pontic—porcelain fused to predominantly base metal	$ 280.00
D6242*	Pontic—porcelain fused to noble metal	$ 280.00
D6750*	Crown—porcelain fused to high noble metal	$ 280.00
D6751	Crown—porcelain fused to predominantly base metal	$ 280.00
D6752*	Crown—porcelain fused to noble metal	$ 280.00
D6790*	Crown—full cast high noble metal	$ 280.00
D6791	Crown—full cast predominantly base metal	$ 280.00
D6792*	Crown—full cast noble metal	$ 280.00
D6930	Recement fixed partial denture (per unit)	$ 10.00

Endodontics		Member pays
D3220	Therapeutic pulpotomy	$ 35.00
D3221	Pulpal debridement, primary and permanent teeth	$ 100.00
D3310	Root canal therapy—anterior (excluding final restoration)	$ 100.00
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$ 200.00
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$ 250.00
D3410	Apicoectomy/periradicular surgery—anterior	$ 125.00

Periodontics (gum treatment)		Member pays
D4210	Gingivectomy/gingivoplasty 4+ teeth, per quad	$ 125.00
D4211	Gingivectomy/gingivoplasty 1-3 teeth, per quad	$ 40.00
D4341	Periodontal scaling and root planing 4+ teeth, per quad	$ 50.00
D4342	Periodontal scaling and root planing 1 to 3 teeth per quadrant	$ 50.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$ 45.00
D4381	Localized delivery of chemotherapeutic agents (per tooth)	$ 45.00
D4910	Periodontal maintenance	$ 50.00

Prosthodontics		Member pays
D5110	Complete denture—maxillary	$ 300.00+lab
D5120	Complete denture—mandibular	$ 300.00+lab
D5130	Immediate denture—maxillary	$ 300.00+lab
D5140	Immediate denture—mandibular	$ 300.00+lab
D5211	Maxillary partial denture—resin base	$ 300.00+lab
D5212	Mandibular partial denture—resin base	$ 300.00+lab
D5213	Maxillary partial denture—cast metal framework, resin denture bases	$300.00+lab
D5214	Mandibular partial denture—cast metal framework, resin denture bases	$300.00+lab
D5410	Adjust complete denture—maxillary	$ 15.00
D5411	Adjust complete denture—mandibular	$ 15.00
D5421	Adjust partial denture—maxillary	$ 15.00
D5422	Adjust partial denture—mandibular	$ 15.00

Repairs to prosthetics		Member pays
D5510	Repair broken complete denture base	$ 15.00+lab
D5520	Replace missing or broken teeth—complete denture (each tooth)	$ 15.00+lab
D5610	Repair resin denture base	$ 15.00+lab
D5630	Repair or replace broken clasp—per tooth	$ 15.00+lab
D5640	Replace broken teeth—per tooth	$ 15.00+lab
D5650	Add tooth to existing partial denture	$ 30.00+lab
D5730	Reline complete maxillary denture (chairside)	$ 50.00
D5731	Reline complete mandibular denture (chairside)	$ 50.00
D5740	Reline maxillary partial denture (chairside)	$ 50.00
D5741	Reline mandibular partial denture (chairside)	$ 50.00
D5750	Reline complete maxillary denture (laboratory)	$ 35.00+lab
D5751	Reline complete mandibular denture (laboratory)	$ 35.00+lab
D5760	Reline maxillary partial denture (laboratory)	$ 35.00+lab
D5761	Reline mandibular partial denture (laboratory)	$ 35.00+lab
D5850	Tissue conditioning—maxillary	$ 30.00
D5851	Tissue conditioning—mandibular	$ 30.00

Extractions/oral and maxillofacial surgery		Member pays
D7111	Extraction, coronal remnants – primary tooth	no charge
D7140	Extraction, erupted tooth or exposed tooth	no charge
D7210	Surgical removal of erupted tooth	$ 40.00
D7220	Removal of impacted tooth—soft tissue	$ 50.00
D7230	Removal of impacted tooth—partially bony	$ 70.00
D7240	Removal of impacted tooth—completely bony	$ 85.00
D7250	Surgical removal of residual tooth roots	$ 35.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	$ 35.00
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 35.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	$ 70.00
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 70.00
D7510	Incision and drainage of abscess—intraoral	$ 25.00

Anesthesia		Member pays
D9215	Local anesthesia	no charge
D9230	Analgesia (nitrous oxide), per 15 minutes	$ 15.00

Adjunctive general services		Member pays
D9450	Case presentation, detailed and extensive treatment planning.	no charge
D9951	Occlusal adjustment—limited	$ 25.00
D9952	Occlusal adjustment—complete	$ 150.00

Orthodontics	Member pays

NOTE: Employees can receive a 25 percent savings by visiting an in-network orthodontists.

* The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.

Note:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply on non-covered services. Visit **Humana.com** to find a participating dentist.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $50 per unit.
- If you break your appointment with your dentist without 24-hour advance notice, you will be subject to your dentist's broken appointment fee.
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits.

Insured or administered by CompBenefits Dental, Inc. or CompBenefits Company

Humana®

Humana.com

Humana Vision 130
Associated Credit Union

Humana Insight Network

GEORGIA

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 $40	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

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.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

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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.

Questions?

Call (678) 325-4645

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Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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