



## RISK MANAGEMENT DEPARTMENT

Fort Bend County, Texas

Wyatt O. Scott  
Director

Phone: 281-341-8630  
Fax: 281-341-3751

TO: Gilbert Jalomo  
Purchasing Agent

FROM: Wyatt Scott  
Director of Risk Management

DATE: September 21, 2016

SUBJECT: 2017 Humana CompDent and Vision Care Plan Renewals

Humana has offered to continue to offer the Optional CompDent Benefit for 2017 with no increases in rates or administration fee.

Humana has also offered to replace a discontinued Visioncare Plan with another Vision Care plan with a 5% increase in premium. The increase is due to the transitioning to the new product "that is designed to be more competitive in the market". The new plan includes enhancing the benefits increasing frame allowance from \$50 to \$130 and increasing contacts allowance from \$105 to \$130. The rates are increasing with a difference of \$0.35 cents to \$1.16 bi-weekly depending on selected tier of coverage. This is an optional benefit that is selected by and paid by the participant.

Risk Management recommends renewing both of the proposed benefits.

Please submit these renewals to Commissioners Court for approval.

Thank you,

A handwritten signature in black ink, appearing to be "Wyatt Scott", is written over a printed name.

Wyatt Scott  
Director of Risk Management



# CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.  
 Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

## OFFICE USE ONLY CERTIFICATION OF FILING

**1 Name of business entity filing form, and the city, state and country of the business entity's place of business.**  
 CompBenefits Insurance Company  
 Houston, TX United States

**Certificate Number:**  
 2016-90844

**Date Filed:**  
 07/26/2016

**Date Acknowledged:**  
 09/27/2016

**2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.**  
 Fort Bend County

**3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.**  
 Group #5274 and VS338  
 Group dental and vision insurance

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary

**5 Check only if there is NO Interested Party.**

**6 AFFIDAVIT** I swear, or affirm, under penalty of perjury, that the above disclosure is true and correct.

\_\_\_\_\_  
 Signature of authorized agent of contracting business entity

AFFIX NOTARY STAMP / SEAL ABOVE

Sworn to and subscribed before me, by the said \_\_\_\_\_, this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, to certify which, witness my hand and seal of office.

\_\_\_\_\_  
 Signature of officer administering oath      Printed name of officer administering oath      Title of officer administering oath



9 Greenway Plaza  
Suite 2000  
Houston, TX 77046

T 713.513.4920  
C 281.389.5771

srahmangarcia@humana.com

July 12, 2016

Ms. Darlene D. Wieghat  
301 Jackson Street  
Suite 224  
Richmond, TX 77469

RE: Humana Annual Renewal Information – Dental and Vision Plans 2017 Contract Year  
Dental DHMO Group Number 5274  
Vision Group Number VS338

Dear Ms. Wieghat:

On behalf of Humana I am pleased to present our renewal rates for the current dental and vision plans.

**Dental Plan**

It is worth noting that the Dental DHMO rates have not changed since 2014 and we will continue with them with a guarantee through December 31, 2017, as outlined below.

**Current and Renewal DHMO Rates**

EE	\$10.98
EE+SP	\$20.00
EE+CH	\$21.32
Family	\$29.84

**Vision Plan**

Beginning this month in Texas, Humana will be discontinuing its current vision plans upon each group's upcoming renewal and transitioning them to a refreshed suite of plans that are designed to be more competitive in the market place.

Your current plan's rates are calling for an increase of more than 10%. However, by transitioning to a new plan, the increase to the current rate is minimized to 5%. In addition we will guarantee this rate for 2-years through December 31, 2018, as outlined below.

**Current Vision Rates**

EE	\$6.92
EE+SP	\$13.80
EE+CH	\$13.10
Family	\$23.18

**Renewal Vision Rates**

EE	\$7.27
EE+SP	\$14.49
EE+CH	\$13.76
Family	\$24.34

The plan being offered closely aligns to the current benefits. Attached is a comparison of the old and new plan with rates along with a benefit summary of the new plan, HV130. Also included is the required disclosure notice regarding the discontinuation of the old plan.

Please let me know if you have any questions about this renewal including the new vision plan that we are Fort Bend County employees. Lastly, Humana thanks you for your business, and we look forward to our continued relationship.

Sincerely,

*Sabina*

Sabina Rahman-Garcia  
Health Solutions Client Executive

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 • Retinal imaging <sup>1</sup>	\$10 Up to \$39	Up to \$30 Not covered
Contact lens exam options <sup>2</sup> • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to \$55 10% off retail	Not covered Not covered
Frames <sup>3</sup>	Up to \$130 20% off balance over \$130	Up to \$65
Standard plastic lenses <sup>4</sup> • Single vision • Bifocal • Trifocal • Lenticular	\$15 \$15 \$15 \$15	Up to \$25 Up to \$40 Up to \$60 Up to \$100
Covered lens options <sup>4</sup> • UV coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Premium anti-reflective coating - Tier 1 - Tier 2 - Tier 3 • Standard progressive (add-on to bifocal) • Premium progressive - Tier 1 - Tier 2 - Tier 3 - Tier 4 • Photochromatic / plastic transitions • Polarized	\$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90, 80% of charge, then up to \$120 \$75 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered
Contact lenses <sup>5</sup> (applies to materials only) • Conventional • Disposable • Medically necessary	Up to \$130, 15% off balance over \$130 Up to \$130 \$0	Up to \$104 Up to \$104 Up to \$200

## Humana Vision 130

### 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

- <sup>1</sup> Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
- <sup>2</sup> 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.
- <sup>3</sup> Discounts available on all frames except when prohibited by the manufacturer.
- <sup>4</sup> Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
- <sup>5</sup> 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.

## 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.

## 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<sup>1</sup>.



<sup>1</sup> Thompson Media Inc.

## Questions

Check out [Humana.com](http://Humana.com)

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

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.

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.

# Humana.

Plan summary created on: 7/12/16 11:09

Policy number: TX-70148-019/15et.al.

Page 3 of 3





Your new rates for the next benefit period are as follows:

1/1/2017 Effective Date with a 2 year Rate Guarantee Period: 1/1/2017 - 12/31/2018

	<b>Current Plan (Discontinued*)</b>	<b>New Plan</b>
Plan Name:	VCP	Humana Vision 130
Exam Copay (In):	\$10	\$10
Materials Copay (In):	\$15	\$15
Frame Allowance (In):	\$50	\$130
Contact Lens Allowance (In):	\$105	\$130
Frequency (In):	12/12/24	12/12/24
	<b>Current Monthly Rates</b>	<b>New Monthly Rates</b>
Employee Only:	\$6.92	\$7.27
Employee & Spouse:	\$13.80	\$14.49
Employee & Child(ren):	\$13.10	\$13.76
Employee & Family:	\$23.18	\$24.34

\*You should have received a letter from Humana notifying you that your current plan is being discontinued

# Humana.

## Important vision plan information

As you have been made aware through this renewal experience, Humana is offering new vision plans. These new vision plans have features designed to help our customers get the most out of their vision benefits, which may include a larger network, easier to understand benefits, and wellness features. In order to fulfill our contractual obligations official notice regarding the discontinuance of the current vision plan will take place 180 days before the actual renewal date. Notification will be sent directly to the agent and the group. The vision product discontinuance communication will not impact the results of this renewal. However, if you would like to consider other Humana vision plan options, please do not hesitate to contact your agent or your Humana Sales Associate.

GCHJEA3EN