Choose a participating eye care provider and save

When you visit an eye care provider who participates in the HumanaVision VCP network, you can save up to 52 percent on an exam and eyewear. Plus, the VCP network is nationwide so you can find a participating provider near your home or work.

The chart below shows an example of how you might save if a participating HumanaVision VCP provider provides services and materials.

We're here to help.

To speak with a HumanaVision Customer Care representative call 1-866-537-0229.

	Average retail cost[1]	VCP	Savings with VCP provider
Exam	$90	$10 copay	$80
Frame	$120[2]	$40 wholesale allowance	$80
Single-vision lenses[3]	$70[4]	$15 copay	$55
Total savings for single-vision eyeglasses (with eye exam)			**$215**

Find a participating provider

Log on to **HumanaVisionCare.com** anytime and select the HumanaVision VCP provider locator. You also can call a Customer Care representative at 1–866–537–0229 from 8 a.m. – 8 p.m. Monday – Thursday and 8 a.m. – 6 p.m. Friday, Eastern time.

Refer your provider

If your eye care provider doesn't participate, please help us get your provider in the VCP network. That way, you can continue to see the provider you know and trust while receiving the best value from your plan. Simply add your name to the card below, give it to your eyecare provider at your next visit, and ask him/her to return it to Humana.

[1] Average retail costs may vary.
[2] Based on a multiple of three times the wholesale cost.
[3] Standard uncoated plastic.
[4] Average retail cost for single-vision eyeglasses does not include additional cost for lens options such as UV coating and anti-reflective coating.

Examples are for illustration only. Actual savings may vary.

HUMANA®

GN-67617-HV 11/11

Join the HumanaVision VCP Network

Your patient wants you to join our network.
For details, complete and mail this card, or fax to 866-454-0070. Thank you!

Please print

Refer your provider

Add your name and give this card to your provider to return to us. We'll make sure he/she gets the details about participating in the HumanaVision VCP Network.

Date
_____

Provider's name
_____

Facility Name
_____

Address
_____

City _____ State _____ ZIP code _____

Telephone with area code
_____

_____ referred you to the HumanaVision VCP Network.
Patient name / employer group

BUSINESS REPLY MAIL

FIRST-CLASS MAIL   PERMIT NO. 434   TAMPA, FL

POSTAGE WILL BE PAID BY THE ADDRESSEE

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