

## About your plan

Humana knows that good vision health is important to overall health. That's why we're committed to making sure that members get the most value from their vision benefit.

Having your eyes checked every year can help detect vision-related complications, including glaucoma, cataracts, and diabetic retinopathy – the leading cause of blindness among adults<sup>1</sup> and the most common eye complication in diabetic patients<sup>2</sup>.

With the Focus plan, members have access to one of the largest vision networks in the United States\*, with optometrists and ophthalmologists at more than 125,000 access points, including both independent and national retail locations such as LensCrafters®, Pearle Vision®, and Target Optical®. Visit [Humana.com/Find-Care](https://www.humana.com/Find-Care) to find a network provider near you.

Staying in-network helps you save money on eye exams, frames and lenses.

You also have access to exclusive, member-only discounts on vision-related products and services when you visit an in-network provider. The discounts are easily accessible from the plan's website at [Humana.com](https://www.humana.com) and can be used above and beyond your vision benefit; they are not part of the insurance plan. Please contact your provider or see the online provider locator to determine which participating providers have agreed to the discounted rate.

**Who can enroll in this plan** – Anyone can enroll in this plan.

## How your plan works

As a member of the Focus plan, you can:

- Use the on-line provider locator to find a network eye care provider at [Humana.com/Find-Care](https://www.humana.com/Find-Care).
- Purchase eyewear and contact lenses at the provider's office or on-line with a valid prescription.
- Stay in-network to lower your out-of-pocket costs, and your in-network provider will handle the claims paperwork.

This plan has no waiting periods.

## Vision care services

	In-network	Out-of-network
<b>Exam</b> (Once every 12 months from the date of service)		
<ul style="list-style-type: none"> <li>Exam with dilatation as necessary</li> </ul>	\$10 copay	\$30 allowance
<b>Contact lens exam options</b> (Unlimited)		
<ul style="list-style-type: none"> <li>Standard contact lens fit and follow-up</li> </ul>	Up to \$40	Not covered
<ul style="list-style-type: none"> <li>Premium contact lens fit and follow-up</li> </ul>	10% off retail price	Not covered
<b>Frames</b> (Once every 24 months from the date of service)		
<ul style="list-style-type: none"> <li>Frames<sup>†</sup></li> </ul>	\$0 copay (20% off balance over \$100 allowance)	\$50 allowance
<b>Lens options</b> (Once every 12 months from the date of service)		
<ul style="list-style-type: none"> <li>Single vision</li> </ul>	\$25 copay	\$25 allowance
<ul style="list-style-type: none"> <li>Bifocal</li> </ul>	\$25 copay	\$40 allowance
<ul style="list-style-type: none"> <li>Trifocal</li> </ul>	\$25 copay	\$55 allowance
<ul style="list-style-type: none"> <li>Lenticular</li> </ul>	20% off retail price	Not covered
<ul style="list-style-type: none"> <li>Progressive lenses - standard</li> </ul>	\$90 copay	\$40 allowance
<ul style="list-style-type: none"> <li>UV coating</li> </ul>	\$15	Not covered
<ul style="list-style-type: none"> <li>Tint (solid and gradient)</li> </ul>	\$15	Not covered
<ul style="list-style-type: none"> <li>Standard scratch - resistant plastic</li> </ul>	\$15	Not covered
<ul style="list-style-type: none"> <li>Standard polycarbonate</li> </ul>	\$40	Not covered
<ul style="list-style-type: none"> <li>Standard anti-reflective coating</li> </ul>	\$45	Not covered
<ul style="list-style-type: none"> <li>Premium anti-reflective coating</li> </ul>	20% off retail price	Not covered
<ul style="list-style-type: none"> <li>Other add-ons and services</li> </ul>	20% off retail price	Not covered
<b>Contact lenses</b> (In lieu of frames and lens services; one every 12 months from the date of service) <sup>†</sup>		
<ul style="list-style-type: none"> <li>Conventional</li> </ul>	\$0 copay (15% off balance over \$115 allowance)	\$92 allowance
<ul style="list-style-type: none"> <li>Disposable</li> </ul>	\$0 copay \$115 allowance	\$92 allowance
<ul style="list-style-type: none"> <li>Medically Necessary</li> </ul>	\$0 copay for materials	\$200 allowance

## Vision care services (continued)

In-network

Out-of-network

### Laser vision correction

- Lasik or photorefractive keratectomy (PRK) from U.S. Laser Network

15% off retail price or 5% off promotional price

Not covered

\* Based on the EyeMed Insight network, October 2018.

† Members eligible for 40% off additional frames, lenses, and lens options purchased as a complete paid. They may use the discount program as well if it offers a better deal -- they should work with their eyecare provider for details.

‡ Plan allows the member to receive either contacts and frame, or frame and lens services.

Discounts are not insurance. These are only available from participating in-network providers and are subject to change without notice.

### Additional details

Member receives a 20% discount on items not covered by the plan at in-network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits.

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. Visit [Humana.com/Find-Care](https://www.humana.com/Find-Care) or call **844-608-2020** to find a provider near you.

Allowance means the maximum amount we will pay for a covered service as shown in the "Schedule of Policy Benefits". The covered person is responsible for payment of any amounts in excess of the allowance. In the event the dollar amount of the covered service is less than the allowance amount shown in the "Schedule of Policy Benefits", then we will only pay up to the actual dollar amount of the covered service.

**Important to know:** Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period. A one-time, non-refundable enrollment fee may apply (the fee is non-refundable as allowed by state requirements). Applicable fees are disclosed at time of enrollment.

### Footnotes:

1. "Common Eye Disorders and Diseases," Centers for Disease Control and Prevention, last accessed Dec. 5, 2023, <https://www.cdc.gov/visionhealth/basics/ced/index.html>

2. "Diabetic Eye Disease Resources," National Eye Institute, last accessed Dec. 5, 2023, <https://www.nei.nih.gov/learn-about-eye-health/outreach-resources/diabetic-eye-disease-resources>

## Limitations and exclusions

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This is an outline of the limitations and exclusions for this Humana Focus plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. In addition to any limitations and exclusions listed in the “Schedule of Policy Benefits” or “Definition” sections, the policy does not provide benefits for the following:

### Limitations

1. The policy will not cover any Service not specifically listed in Your Schedule of Benefits. Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

### Exclusions – We will not cover:

1. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), and state or Federal workers’ compensation or occupational disease act or law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made;
2. Any loss caused or contributed by:
  - a. War or act of war, (whether declared or not); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto;
  - b. Suicide, attempted suicide or intentionally self-inflicted injury; and
  - c. Aviation, other than as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline;
3. Cosmetic items, except that cosmetic items shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. However, if the policy provides hospital, surgical or medical expense coverage, including a policy issued by a health maintenance organization, then coverage and determinations with respect to cosmetic surgery must be provided pursuant to Part 56 of this Title (Regulation 183);
4. Any Service that:
  - a. Is not medically necessary;
  - b. Does not offer a favorable prognosis; or
  - c. Does not have uniform professional endorsement;
5. Service while You are outside the United States, its possessions or the countries of Canada and Mexico;
6. Any Expense Incurred to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation;
7. Any Expenses Incurred in consequence of Your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Insured by Humana Insurance Company of New York.

Policy number: HUMV-IP.001-NY (2/09)

Applications are subject to approval. This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control. Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.

Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts may be available.

EyeMed (the Vendor) is a third-party vendor. Humana's contract with the Vendor does not eliminate a member of any obligations under the policy or change the terms of the policy. Participation in a Vendor's program is voluntary. All representations and warranties contained in this marketing material are made solely by the Vendor, not Humana. Humana and the Vendor, including each party's respective affiliates and subsidiaries, are independent, non-affiliated entities. Humana, its parent and affiliates are not liable to members for the negligent provision of services by the Vendor.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.



## 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, ethnicity, marital status, religion, or language. 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 **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, **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: **800-927-HELP (4357)**, to file a grievance.

### Auxiliary aids and services, free of charge, are available to you. 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. 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):** Wóda hí béesh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

GCHJV5REN 0721

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك