Vision Care Plan (VCP)

Having your eyes checked every year can help prevent vision-related complications, including glaucoma, cataracts, and diabetic retinopathy-the leading cause of blindness among adults[1] and the most common eye complication in diabetic patients[2].

Vision Care Plan options have you covered and make eye care affordable. You have access to one of the largest vision networks in the United States, with more than 35,000 participating optometrists, ophthalmologists, and national retail locations, including LensCrafters®, Pearle Vision®, and Target® Optical. In addition you'll enjoy the same benefits at all participating providers, no matter where they're located.

How your plan works

Vision care services	In-network provider (member cost)	Out-of-network provider (member reimbursement)
Examination		
• Examination with dilation as necessary	$10 copay	Up to $35
Contact lens exam options		
• Fit and followup - standard [3]	Up to $40	Not covered
• Fit and followup - premium	10% off retail price	Not covered
Frames		
• Frames	$120 retail allowance ($0 copay, 20% off balance over the $120 allowance)	Up to $40
Standard plastic lenses		
• Single vision (materials only)	$0 copay	Up to $25
• Bifocal	$0 copay	Up to $40
• Trifocal	$0 copay	Up to $60
• Lenticular	$0 copay	Up to $100
Lens options		
• Progressive - (add-on to bifocal)	$60 copay	Up to $60
• Anti-reflective coating - standard	$45 copay	Not covered
• Photochromic - non-glass	$75 copay	Not covered
• Polycarbonate - standard (age 19 and over)	$40 copay	Not covered
• Polycarbonate - standard (under age 19)	$0 copay	Not covered
• Scratch coating - standard plastic	$15 copay	Not covered
• Tint - solid or gradient	$15 copay	Not covered
• UV treatment	$15 copay	Not covered
• All other lens options	20% off retail price	Not covered

Vision care services	In-network provider (member cost)	Out-of-network provider (member reimbursement)
Contact lenses [5]		
• Conventional	$115 allowance (15% off balance over $115 allowance)	Up to $90
• Disposable	$115 allowance	Up to $90
• Medically necessary (limit one pair) [4]	$0	Up to $120
Frequency		
• Examination • Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
• Frames	Once every 24 months from the date of service	Once every 24 months from the date of service
• Contact lenses [3]	Once every 12 months from the date of service	Once every 12 months from the date of service

Footnotes -

[1] NIH MedlinePlus, "Leading Causes of Blindness,"

http://www.nlm.nih.gov/medlineplus/magazine/issues/summer08/articles/summer-08pg14-15.html.

[2] National Eye Institute, Prevent Blindness America®.
[3] The contact lens allowance is for materials only. Contact lens fitting allowance is up to $40.
[4] Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior authorization.
[5] If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).

Plan discounts -

- Member receives a 20% discount on items not covered by the plan at in-network provider 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 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 the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
- Service and amounts listed above are subject to change at any time.
- Additional frame and lenses purchased together are a 40% discount.
- Additional frame or lenses purchased separately are a 20% discount.
- Additional conventional contact lenses are a 15% discount.
- Member may also receive 15% off retail price or 5% off any promotional price of LASIK or PRK from the US laser network, owned by LCA-Vision. Since LASIK or PRK Vision Correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location.

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Limitations and Exclusions

This is an outline of the limitations and exclusions for this Vision plan. It is designed for convenient reference. Consult the plan certificate for a complete list of limitations and exclusions.

Limitations - In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits;
3. The negotiated fee when services are rendered by Network Providers; or
4. The allowance as shown in the Schedule of Benefits when services are rendered by Non-Network Providers.

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.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish; unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions - We will not cover:

1. Orthopic or vision training and any associated supplemental testing.
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives.
3. Medical or surgical treatment of the eye, eyes or supporting structures.
4. Any services and/or Materials required by an employer as a condition of employment or safety eyewear, unless covered under the Policy.
5. Any injury or illness covered under any Workers' Compensation or similar law.
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses.
7. Charges incurred before the Insured's effective date or after the Insured's coverage under the Policy ends.
8. Contact lenses, except as specifically covered by the Policy.
9. Hi Index, aspheric and non-aspheric styles.
10. Oversized 61 and above lens or lenses.
11. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.
12. Services or Materials:
    a. 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;
    b. furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid);
    c. furnished by any U.S. government-owned or operated hospital/institution/agency for any service or Material connected with sickness or bodily injury.
13. 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.
14. Any services or Materials not listed as a covered benefit in the Schedule of Benefits.
15. Broken appointment fees.
16. Any expense arising from completion of forms.
17. Prescription drugs or medications, whether dispensed or prescribed.
18. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
19. 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 non- conventional treatment or device.
20. Services provided by someone who ordinarily lives in the Insured's home or is related to the Insured by blood, marriage or adoption.
21. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
22. Pathological treatment.

Limitations and Exclusions (continued)

This is an outline of the limitations and exclusions for this Vision plan. It is designed for convenient reference. Consult the plan certificate for a complete list of limitations and exclusions.

Exclusions - We will not cover:

23. Non-prescription Materials.
24. Costs associated with securing materials.
25. Pre- and post-operative services.
26. Orthokeratology.
27. Routine maintenance of Materials.
28. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the Policy.
29. Artistically painted lenses

Check with your local Humana sales office to verify product availability.

Insured by Humana Insurance Company

Additional details

- Date of Service benefits will not be available again until the same date in the following year(s) when a member has active coverage.
- This plan allows the member to receive either contacts and frame, or frame and lens services.
- After signing up for your vision plan, you will receive a Humana member ID card in the mail.
- Prior to scheduling your appointment, select an in-network provider through the Customer Care Center automated information line, or Humana.com/Vision.
- Schedule an appointment, providing your name or the patient's name.
- Sign your provider's form after your exam and pay any copays and/or costs of any upgrades at this time.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE EST. 1961 VISION TARGET OPTICAL

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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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