Humana Vision 160

(100+ employees)

		If you use an IN-NETWORK provider (Member Cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Routine eye exam	Exam with dilation, as necessary	$10	Up to $30
	Retinal imaging[1]	Up to $39	Not covered
Contact lens[2] exam options	Standard contact lens fit and follow-up	$0	Up to $30
	Premium contact lens fit and follow-up	10% off retail less $55 allowance	Up to $30
Frames*		$160 allowance, 20% off balance over $160	$80 allowance
Standard plastic lenses[3]	Single vision	$10	Up to $25
	Bifocal	$10	Up to $40
	Trifocal	$10	Up to $60
	Lenticular	$10	Up to $100
Lens options[3]	UV coating	$15	Not covered
	Tint (solid and gradient)	$15	Not covered
	Standard scratch-resistance	$15	Not covered
	Standard polycarbonate		
	• Adults	$40	Not covered
	• Children <19	$40	Not covered
	Standard anti-reflective coating	$10	Up to $25
	Premium anti-reflective coating		
	• Tier 1	$22	Up to $25
	• Tier 2	$33	Up to $25
	• Tier 3	80% of charge less $35 allowance	Up to $25
	Standard progressive (add-on to bifocal)	$10	Up to $40
	Premium progressive		
	• Tier 1	$45	Up to $40
	• Tier 2	$55	Up to $40
	• Tier 3	$70	Up to $40
	• Tier 4	$25 copay, 80% of charge less $120 allowance	Up to $40
	Photochromatic / plastic transitions	$75	Not covered
	Polarized	20% off retail	Not covered
Contact lenses[4] (Applies to materials only)	Conventional	$160 allowance, 15% off balance over $160	$128 allowance
	Disposable	$160 allowance	$128 allowance
	Medically necessary	$0	$210 allowance
Frequency	Examination	Once every 12 months	Once every 12 months
	Lenses or contact lenses	Once every 12 months	Once every 12 months
	Frames	Once every 24 months	Once every 24 months

*Discounts may be available on all frames except when prohibited by the manufacturer.

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Diabetic Eye Care (Care and testing for diabetic members)	Exam	$0	Up to $77
	Retinal imaging	$0	Up to $50
	Extended ophthalmoscopy	$0	Up to $15
	Gonioscopy	$0	Up to $15
	Scanning laser	$0	Up to $33
	(Up to 2 services per year for each listed service)		

OPTIONAL BENEFITS	
12-Month Frame Benefit	Benefit replaces the 24-month frequency of the base plan.
Retinal Imaging	$0 in-network and up to $20 for out-of-network benefits. Does not cross apply.
LASIK / PRK	$250 per eye, in- or out-of network; 12-month waiting period applies.
Eye Glass and Contact Lens Benefit	Allows fulfillment of frame plus spectacle lenses in addition to the contact lens benefit of the base plan.
Polycarbonate Lenses for Children <19	Provides for standard polycarbonate lens with $0 copay. Not available in AK, CT, ID, & OH.

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 specially trained providers, this discount may not always be available from a provider in your immediate location.

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 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

4 Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

*NJ- Any services received for emergency care will pay at the same level of benefits for preferred and non-preferred providers.

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

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.

Policy number(s): GN-70148-01 9/15 et.al., AK-70148-01 9/15 et.al., AR-70148-01 9/15 et.al., CA-70148-01 9/15 et.al., CO-70148-01 9/15 et.al., CT-70148-01 9/15 et.al., DC-70148-01 9/15 et.al., FL-70148-01 LG 9/15 et.al., GA-70148-01 9/15 et.al., IA-70148-01 9/15 et.al., ID-70148-01 9/15 et.al., IL-70148-LG 9/15 et.al., IN-70148-01 9/15 et.al., KS-70148-01 9/15 et.al., KY-70148-01 9/15 et.al., LA-70148-01 9/15 et.al., ME-70148-01 9/15 et.al., MI: GN-70148-01 9/15 LG et.al., MN-70148-01 9/15 et.al., MO-70148-01 9/15 et.al., MS-70148-01 9/15 et.al., NC-70148-01 9/15 et.al., ND-70148-01 9/15 et.al., NE-70148-01 9/15 et.al., NH-70148-01 9/15 et.al., NV-70148-01 9/15 et.al., NY-70148-01 9/15 et.al., OK-70148-01 9/15 et.al., PA-70148-01 9/15 LG et.al., SC-70148-01 9/15 et.al., SD-70148-01 9/15 et.al., TN-70148-01 9/15 et.al., TX-70148-01 9/15 et.al., UT-70148-01 9/15 et.al., VT-70148-01 9/15 et.al., VA-70148-01 9/15 et. al., WV-70148-01 9/15 et.al., WI-70148-01 9/15 et.al.

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Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235（TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-320-1235（TTY：711）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-320-1235 (TTY: 711).