

Humana Vision Plan

		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	\$0	Up to \$20
Contact lens exam options ¹	Standard contact lens fit and follow-up	Up to \$55	Not covered
	Premium contact lens fit and follow-up	10% off retail	Not covered
Frames*		\$130 allowance, 20% off balance over \$130	\$65 allowance
Standard plastic lenses ²	Single vision	\$0 Up to \$25	Up to \$25
	Bifocal	\$0 Up to \$40	Up to \$40
	Trifocal	\$0 Up to \$60	Up to \$60
	Lenticular	\$0	Up to \$100
Lens options ²	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	\$0	Not covered
	Standard anti-reflective coating	\$45	Not covered
	Premium anti-reflective coating		
	• Tier 1	\$57	Not covered
	• Tier 2	\$68	Not covered
	• Tier 3	80% of charge	Not covered
	Standard progressive (add-on to bifocal)	\$15	Up to \$40
	Premium progressive		
	• Tier 1	\$110	Not covered
	• Tier 2	\$120	Not covered
• Tier 3	\$135 N	Not covered	
• Tier 4	\$90, 80% of charge, less \$120 allowance	Not covered	
Photochromatic / plastic transitions	\$75	Not covered	
Polarized	20% off retail	Not covered	

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

Humana Vision 130

**If you use an
IN-NETWORK
provider
(Member cost)**

**If you use an
OUT-OF-NETWORK
provider
(Reimbursement)**

		If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Contact lenses³ (applies to materials only)	Conventional	\$130 allowance, 15% off balance over \$130	\$104 allowance
	Disposable Medically necessary	\$130 allowance \$0	\$104 allowance \$200 allowance
Frequency	Examination	Once every plan year	Once every plan year
	Lenses or contact lenses	Once every plan year	Once every plan year
	Frame	Once every 2 plan years	Once every 2 plan years
Diabetic Eye Care⁴ (Care and testing for diabetic members)	Exam	\$0	Up to \$77
	Retinal Imaging (not covered if an extended ophthalmoscopy has been done in the last 6 months)	\$0	Up to \$50
	Extended Ophthalmoscopy (not covered if retinal imaging has been done in the last 6 months)	\$0	Up to \$15
	Gonioscopy Scanning Laser (Up to 2 services per plan year for each listed service)	\$0 \$0	Up to \$15 Up to \$33
Hypertensive Eye Care⁴ (Care and testing for members with hypertension)	Exam	\$0	Up to \$77
	Retinal Imaging (not covered if extended ophthalmoscopy has been done in the last 6 months) (Up to 2 services per plan year for each listed service)	\$0	Up to \$50

¹ 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.

² Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

³ Plan covers contact lenses or frames, but not both.

⁴ There is cross-reduction if both diabetes and hypertensive eye care benefits are used. No more than 2 total medical office visits and 2 retinal imaging examinations will be payable in a 12 month period under this plan.

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

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.

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 anesthesiologist.
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.

continued on next page

Limitations and exclusions, *continued*

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.

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'í 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)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك