Humana Vision PLUS

Individual Vision

Georgia

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[1] and the most common eye complication in diabetic patients[2].

With the Humana Vision PLUS 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** to find a network provider near you.

Staying in-network helps you save money on eye exams, frames and lenses, and visiting a designated PLUS Provider will save you even more. Since PLUS Providers are already in our vision network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

You also have access to exclusive, member-only special offers and discounts on vision-related products and services. The offers and discounts are easily accessible from the plan's website at **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 Humana Vision PLUS plan, you can:

- Use the on-line provider locator to find a network eye care provider at **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.
- Visit an in-network PLUS provider to receive additional benefits†.

This plan has no waiting periods.

Vision care services	PLUS In-network	In-network	Out-of-network
Exam (One every 12 months from the last date of service)			
• Exam†	$0 copay	$10 copay	$30 allowance
• Retinal imaging	$39	$39	Not covered
Contact lens exam options (One every 12 months from the last date of service)			
• Standard contact lens fit and follow-up	$0	$0	Not covered
• Premium contact lens fit and follow-up	10% off retail price	10% off retail price	Not covered
Frames (One every 12 months from the last date of service)			
• Frames†	$0 copay $250 allowance (20% off balance over $250)	$0 copay $200 allowance (20% off balance over $200)	$200 allowance
Lens options (One every 12 months from the last date of service)			
• Single vision	$10 copay	$10 copay	$25 allowance
• Bifocal	$10 copay	$10 copay	$40 allowance
• Trifocal	$10 copay	$10 copay	$55 allowance
• Lenticular	20% off retail price	20% off retail price	Not covered
• Progressive lenses - standard (add-on to bifocal)	$65 copay	$65 copay	$65 allowance
• Progressive lenses - tier 1	$100	$100	Not covered
• Progressive lenses - tier 2	$110	$110	Not covered
• Progressive lenses - tier 3	$125	$125	Not covered
• Progressive lenses - tier 4[3]	$90; 20% off retail price less $120 allowance	$90; 20% off retail price less $120 allowance	Not covered
• Anti-reflective coating – standard	$25	$25	Not covered
• Anti-reflective coating – premium tier 1	$25	$25	Not covered
• Anti-reflective coating – premium tier 2	$68	$68	Not covered
• Anti-reflective coating – premium tier 3	20% off retail price	20% off retail price	Not covered
• Photochromic – non-glass	$75	$75	Not covered
• UV coating	$0	$0	Not covered

Vision care services (continued)	PLUS In-network	In-network	Out-of-network
Lens options (continued) (One every 12 months from the last date of service)			
• Tint (solid and gradient)	$0	$0	Not covered
• Standard scratch coating – plastic	$0	$0	Not covered
• Standard polycarbonate – age 19 and older	$20	$20	Not covered
• Standard polycarbonate – age 18 and younger	$0	$0	Not covered
• Other add-ons and services	20% off retail price	20% off retail price	Not covered
Contact lenses (In lieu of lenses; one every 12 months from the last date of service)‡			
• Conventional	$200 allowance (15% off balance over $200)	$200 allowance (15% off balance over $200)	$92 allowance
• Disposable	$200 allowance	$200 allowance	$92 allowance
• Medically Necessary	$0 copay	$0 copay	$200 allowance
Laser vision correction			
• Lasik or photorefractive keratectomy (PRK) from U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	Not covered
Special offers			
• Other	20% off retail price on items not covered by plan**	20% off retail price on items not covered by plan**	Not covered

* Based on EyeMed Insight network, October 2018.

† See the PLUS In-network column for enhanced Exam and Frames benefits.

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

** Get 40% off a complete second pair of prescription glasses from participating in-network providers. Simply ask your provider, then choose your favorite frames and lenses.

Special offers and 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** 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.

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

3. Tier 4 progressive lens calculation: Multiply retail price by 80%, subtract the $120 allowance, and add $90.

Limitations and exclusions

This is an outline of the limitations and exclusions for this Humana Vision PLUS 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 – In no event will coverage exceed the lesser of:

1. The actual cost of covered services or materials;
2. The limits of this policy, shown in the "Schedule";
3. The negotiated fee when services are rendered by network providers; or
4. The allowance, as shown in the "Schedule", 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.

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

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromic 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;

Exclusions – We will not cover:

1. Orthoptic 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; any hospital, surgical or treatment facility charges; and services of an anesthesiologist or anesthetist; or any pre- and post-operative services;
4. Any services and/or materials required by an employer as a condition of employment or safety eyewear, unless covered under this 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 primary insured's effective date or after the primary insured's coverage under this policy ends;
8. Contact lenses, except as specifically covered by this policy;
9. Hi Index, aspheric, and non-aspheric styles;
10. Oversized 61 and above lens or lenses;
11. Cosmetic and non-prescription materials including but not limited to artistically painted lenses;
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";
15. Broken appointment fees;
16. Any expense arising from completion of forms;
17. Prescription drugs or medications, whether dispensed or prescribed;
18. 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;
19. Services provided by someone who ordinarily lives in the covered person's home or is a family member;
20. Treatment resulting from any intentionally self-inflicted injury or bodily illness;
21. Certain name brands when the manufacturer does not discount;

22. Costs associated with securing materials;
23. Orthokeratology;
24. Routine maintenance of materials;
25. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in this policy; and
26. Medically necessary contacts are not covered for covered persons with a history of corneal or elective refractive surgery (i.e., laser-assisted in-situ keratomileusis (Lasik), photorefractive keratectomy (PRK), radial keratotomy (RK).

Insured by Humana Insurance Company.

Policy number: GA-71142

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.

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): 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

GCHJV5REN 0721