

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 adults¹ and the most common eye complication in diabetic patients².

Humana Vision PLUS has you covered and may help make eye care more affordable. You 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®. In addition you'll enjoy the same benefits at all in-network providers, no matter where they're located. Visit [Humana.com](https://www.humana.com) 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](https://www.humana.com) and can be used above and beyond your vision benefit; they are not part of the insurance plan. New offers are added often, so have a look before scheduling your next eye exam.

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](https://www.humana.com).
- 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)			
<ul style="list-style-type: none"> Exam Retinal imaging[†] 	\$0 copay* \$39	\$10 copay \$39	\$30 allowance Not covered
Contact Exam Options (One every 12 months from the last date of service)			
<ul style="list-style-type: none"> Standard contact lens fit and follow-up Premium contact lens fit and follow-up[†] 	\$0 copay 10% off retail price	\$0 copay 10% off retail price	Not covered Not covered
Frames (One every 12 months from the last date of service)			
<ul style="list-style-type: none"> 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)			
<ul style="list-style-type: none"> Single vision Bifocal Trifocal Lenticular[†] Progressive lenses - standard (add-on to bifocal) <ul style="list-style-type: none"> Progressive lenses - tier 1[†] Progressive lenses - tier 2[†] Progressive lenses - tier 3[†] Progressive lenses - tier 4^{† 3} Anti-reflective coating – standard[†] <ul style="list-style-type: none"> Anti-reflective coating – premium tier 1[†] Anti-reflective coating – premium tier 2[†] Anti-reflective coating – premium tier 3[†] Photochromic – non-glass[†] UV coating[†] 	\$10 copay \$10 copay \$10 copay 20% off retail price \$65 copay \$100 \$110 \$125 \$90, 20% off retail price less \$120 allowance \$25 \$25 \$68 20% off retail price \$75 \$0	\$10 copay \$10 copay \$10 copay 20% off retail price \$65 copay \$100 \$110 \$125 \$90, 20% off retail price less \$120 allowance \$25 \$25 \$68 20% off retail price \$75 \$0	\$25 allowance \$40 allowance \$55 allowance Not covered \$65 allowance Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered

Vision care services	PLUS In-network	In-network	Out-of-network
Lens Options - Continued (One every 12 months from the last date of service)			
<ul style="list-style-type: none"> Tint (solid and gradient)[†] Standard scratch coating – plastic[†] Standard polycarbonate – adults[†] Standard polycarbonate – members under 19[†] Other add-ons and services[†] 	<ul style="list-style-type: none"> \$0 \$0 \$20 \$0 20% off retail price 	<ul style="list-style-type: none"> \$0 \$0 \$20 \$0 20% off retail price 	<ul style="list-style-type: none"> Not covered Not covered Not covered Not covered Not covered
Contact Lenses (In lieu of lenses; one every 12 months from the last date of service) ^{***}			
<ul style="list-style-type: none"> Conventional Disposable Medically Necessary 	<ul style="list-style-type: none"> \$200 allowance (15% off balance over \$200)[†] \$200 allowance \$0 copay 	<ul style="list-style-type: none"> \$200 allowance (15% off balance over \$200)[†] \$200 allowance \$0 copay 	<ul style="list-style-type: none"> \$92 allowance \$92 allowance \$200 allowance
Laser Vision Correction [†]			
<ul style="list-style-type: none"> Lasik or PRK from U.S. Laser Network 	<ul style="list-style-type: none"> 15% off retail price or 5% off promotional price 	<ul style="list-style-type: none"> 15% off retail price or 5% off promotional price 	<ul style="list-style-type: none"> Not covered
Special Offers [†]			
<ul style="list-style-type: none"> Other 	<ul style="list-style-type: none"> 20% off retail price on items not covered by plan^{**} 	<ul style="list-style-type: none"> 20% off retail price on items not covered by plan^{**} 	<ul style="list-style-type: none"> Not covered

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

** 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.

*** Plan allows the member to receive either contacts or eyeglass lens benefits.

[†] 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

Members may receive a 20% discount on items not covered by the plan at in-network providers. Members may contact their in-network provider to determine what costs or discounts are available. Discount does not apply to EyeMed® Provider's professional services, or contact lenses. Plan discounts are not insurance and 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 eye glasses. 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 specialty trained providers, this discount may not always be available from a provider in your immediate location. Visit [Humana.com](https://www.humana.com) to find a provider near you.

You also have access to exclusive, members-only special offers and 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. New offers are added often, so have a look before scheduling your next eye exam.

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: This plan may require a one-year contract.

Footnotes:

¹ Leading Causes of Blindness," NIH MedlinePlus, Summer 2008, accessed March 18, 2022, <https://www.nlm.nih.gov/medlineplus/magazine/issues/summer08/articles/summer-08pg14-15html>.

² National Eye Institute, Prevent Blindness America.

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;

Limitations and exclusions (continued)

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

Applications are subject to approval. Waiting periods may apply; limitations and exclusions apply.

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.

Policy number: GN-71142

**INDEPENDENT
PROVIDER
NETWORK**



LENSCRAFTERS

**PEARLE
EST. 1961
VISION**

OPTICAL

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): Wóadahí béesh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowol.

العربية (Arabic)

GCHJV5REN 0721

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك