Humana Vision

Vision care services	See a participating provider	See a nonparticipating provider
Exam with dilation as necessary	$15 copay	$30 allowance
Contact lens exam options*		
• Standard contact lens fit and follow-up	$40 copay	Not available
• Premium contact lens fit and follow-up	10% off retail	Not available
Frames		
• Discounts may be available on all frames except when prohibited by the manufacturer.	$150 allowance, 20% off balance over $150	$150 allowance
Standard plastic lenses		
• Single vision	$25 copay	$25 allowance
• Bifocal	$25 copay	$40 allowance
• Trifocal	$25 copay	$55 allowance
Lens options		
• UV coating	$15 copay	Not available
• Tint (solid and gradient)	$15 copay	Not available
• Standard scratch-resistance	$15 copay	Not available
• Standard polycarbonate**	$40 copay	Not available
• Standard anti-reflective coating	$45 copay	Not available
• Standard progressive (add-on to bifocal)	$65 copay	Not available
• Other add-ons and services	20% off retail price	Not available
Contact lenses (applies to materials only)		
• Conventional	$150 allowance, 15% off balance over $150	$92 allowance
• Disposable	$150 allowance	$92 allowance
• Medically necessary	15% off balance over $150	$200 allowance
Frequency‡		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 12 months	Once every 12 months

* Standard contact lens fitting: spherical clear contact lenses in conventional wear and planned replacement (examples include by not limited to disposable, frequent replacement, etc.)

* Premium contact lens fitting: all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

** Standard polycarbonate available at no charge to dependents to 19 years old. All other members pay a fixed charge of $40.

‡ Frequencies are based on date of service.

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EyeMed Vision Care®

Questions?

Call 1-877-243-1545 anytime for the automated information line or 8 a.m. to 6 p.m. for a Customer Care specialist.

Additional plan discounts

You may be eligible to receive a discount off retail price on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services or contact lenses. Retail prices may vary by location. Always ask your provider about special offers which may provide a lower overall price.

You may also be eligible to receive a discount off retail price on complete eyeglass purchases and a discount off retail price on conventional contact lenses once the funded benefit has been used.

You may also be eligible to receive a discount off retail price or a discount 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. For a location near you and the discount authorization, please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to you.

Plan 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 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 this 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 this policy. You are responsible for extras selected, including but not limited to the following:

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; and
6. Groove, drill or notch, and roll and polish.

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; 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; if the covered person is eligible
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 or similar 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 (ie. laser-assisted in-situ keratomileusis (LASIK), photorefractive keratectomy (PRK), radial keratotomy (RK).

Vision products insured by The Dental Concern, Inc. This is not a complete disclosure of plan qualifications and limitations.

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