Humana Vision Plans

	100		130/Materials Only 130		160/Materials Only 160		200	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam								
Exam with dilation, as necessary*	$10	Up to $30	$10	Up to $30	$10	Up to $30	$0	Up to $30
Retinal imaging[1]	Up to $39	Not covered	Up to $39	Not covered	Up to $39	Not covered	Up to $39	Not covered
Contact lens exam options[2]								
Standard contact lens fit and follow-up	Up to $55	Not covered	Up to $55	Not covered	$0	Up to $30	$0	Up to $30
Premium contact lens fit and follow-up	10% off retail	Not covered	10% off retail	Not covered	10% off retail, then up to $55	Up to $30	10% off retail, then up to $55	Up to $30
Frames *Discounts available on all frames except when prohibited by the manufacturer*	Up to $100, 20% off balance over $100	Up to $50	Up to $130, 20% off balance over $130	Up to $65	Up to $160, 20% off balance over $160	Up to $80	Up to $200, 20% off balance over $200	Up to $100
Standard plastic lenses[3]								
Single vision	$25	Up to $25	$15	Up to $25	$10	Up to $25	$0	Up to $25
Bifocal	$25	Up to $40	$15	Up to $40	$10	Up to $40	$0	Up to $40
Trifocal	$25	Up to $60	$15	Up to $60	$10	Up to $60	$0	Up to $60
Lenticular	$25	Up to $100	$15	Up to $100	$10	Up to $100	$0	Up to $100
Len options[3]								
UV Coating	$15	Not covered	$15	Not covered	$15	Not covered	$15	Not covered
Tint (solid and gradient)	$15	Not covered	$15	Not covered	$15	Not covered	$15	Not covered
Standard scratch-resistance	$15	Not covered	$15	Not covered	$15	Not covered	$15	Not covered
Standard polycarbonate								
• Adults	$40	Not covered	$40	Not covered	$40	Not covered	$40	Not covered
• Children <19	$40	Not covered	$40	Not covered	$40	Not covered	$40	Not covered
Standard anti-reflective coating	$45	Not covered	$45	Not covered	$10	Up to $25	$0	Up to $25
Premium anti-reflective coating								
• Tier 1	$57	Not covered	$57	Not covered	$22	Up to $25	$22	Up to $25
• Tier 2	$68	Not covered	$68	Not covered	$33	Up to $25	$33	Up to $25
• Tier 3	80% of charge	Not covered	80% of charge	Not covered	80%of charge, then up to $35	Up to $25	80%of charge, then up to $35	Up to $25
Standard progressive (add-on to bifocal)	$25	Up to $40	$15	Up to $40	$10	Up to $40	$0	Up to $40

*Not covered on Materials Only 130 and 160

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	100		130/Materials Only 130		160/Materials Only 160		200	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Premium progressive								
• Tier 1	$110	Not covered	$110	Not covered	$45	Up to $40	$45	Up to $40
• Tier 2	$120	Not covered	$120	Not covered	$55	Up to $40	$55	Up to $40
• Tier 3	$135	Not covered	$135	Not covered	$70	Up to $40	$70	Up to $40
• Tier 4	$90, 80% of charge, then up to $120	Not covered	$90, 80% of charge, then up to $120	Not covered	$25, 80% of charge, then up to $120	Up to $40	$25, 80% of charge, then up to $120	Up to $40
Photochromatic / plastic transitions	$75	Not covered	$75	Not covered	$75	Not covered	$75	Not covered
Polarized	20% off retail	Not covered	20% off retail	Not covered	20% off retail	Not covered	80% of charge	Not covered
Contact Lenses (Applies to materials only)								
Conventional	Up to $100, 15% off balance over $100	Up to $80	Up to $130, 15% off balance over $130	Up to $104	Up to $160, 15% off balance over $160	Up to $128	Up to $200, 15% off balance over $200	Up to $160
Disposable	Up to $100	Up to $80	Up to $130	Up to $104	Up to $160	Up to $128	Up to $200	Up to $160
Medically necessary	$0	Up to $200	$0	Up to $200	$0	Up to $210	$0	Up to $210
Frequency								
Examination	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months
Diabetic Eye Care* Care and testing for diabetic members *Up to 2 services per year for each listed service*								
Exam	$0	Up to $77	$0	Up to $77	$0	Up to $77	$0	Up to $77
Retinal imaging	$0	Up to $50	$0	Up to $50	$0	Up to $50	$0	Up to $50
Extended ophthalmoscopy	$0	Up to $15	$0	Up to $15	$0	Up to $15	$0	Up to $15
Gonioscopy	$0	Up to $15	$0	Up to $15	$0	Up to $15	$0	Up to $15
Scanning laser	$0	Up to $33	$0	Up to $33	$0	Up to $33	$0	Up to $33

***Not covered on Materials Only 130 & 160

Humana Vision Plans

PLAN OPTIONS	
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

*Not available on Materials Only 130 & 160

** Not available for groups < 100

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.

Humana Vision Exam Plus

	Exam Plus	
	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam		
Exam with dilation, as necessary	$10	Up to $30
Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
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 *Discounts available on all frames except when prohibited by the manufacturer*	35% off retail	Not covered
Standard plastic lenses[3]		
Single vision	$50	Not covered
Bifocal	$70	Not covered
Trifocal	$105	Not covered
Lenticular	20% off retail	Not covered
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	$45	Not covered
Standard progressive (add-on to bifocal)	$65	Not covered
Polarized	20% off retail	Not covered
Add-on services	20% off retail	Not covered

	IN-NETWORK	OUT-OF-NETWORK
Contact Lenses (Applies to materials only)		
Conventional	15% off retail	Not covered
Disposable	Not covered	Not covered
Medically necessary	Not covered	Not covered
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or contact lenses	Not covered	Not covered
Frames	Not covered	Not covered

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.

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., AR-70148-01 9/15 et.al., CA-70148-01 9/15 et.al., CO-70148-01 9/15 et.al., DC-70148-01 9/15 et.al., FL-70148-01 LG 9/15 et.al., FL-70148-01 SG 9/15 et.al. GA-70148-01 9/15 et.al., IA-70148-01 9/15 et.al., IL-70148-LG 9/15 et.al. IL-70148-SG 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., MI: GN-70148-LG 9/15 et.al., GN-70148-01-SG 9/15 et.al., MN-70148-01 9/15 et.al., MO-70148-01 9/15 et.al., MS-70148-01 9/15 et.al., NE-70148-01 9/15 et.al., NY-70148-01 9/15 et.al., OK-70148-01 9/15 et.al., PA-70148-LG 9/15 et.al., PA-70148-SG 9/15 et.al., SC-70148-01 9/15 et.al., UT-70148-01 9/15 et.al., WV-70148-01 9/15 et.al., WI-70148-01 9/15 et.al.

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