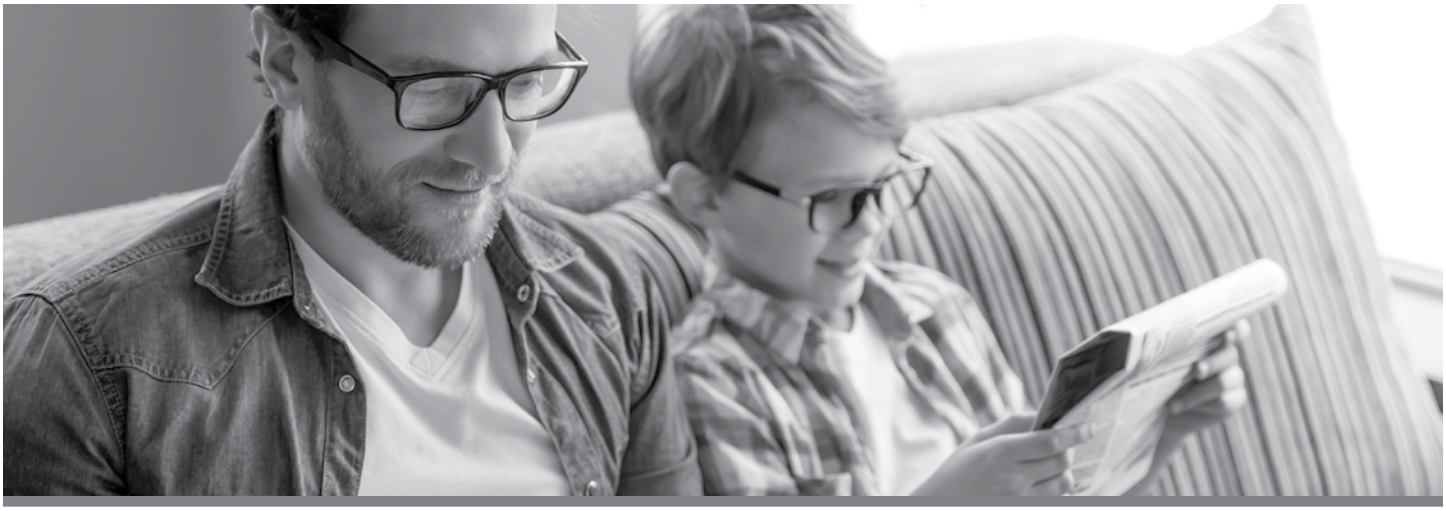
Vision Plans



Humana Insight

The Humana Insight plan offers:

- A $150 +20% frame allowance at $0 copay for members.
- Members will never pay more that $55 for contact lens fitting fees.
- A diabetes vision rider is embedded in this plan. Retinal imaging cost won't exceed $39.
- Humana Insight Network has 70,000 providers nationwide.

	PER PAY PERIOD	
	12 PAY	20 PAY
Employee Only	$7.43	$4.46
Employee + Family	$21.28	$12.77

Lasik

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.

Plan Provider

For questions regarding your vision benefit contact Member Services at
1-877-398-2980,
Mon. – Sat., 7:30 a.m. – 8 p.m. EST,
Sun. 11 a.m. – 8 p.m EST.

Vision Plans

	IN-NETWORK	OUT-OF-NETWORK
FREQUENCY		
Exam	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
EXAMS & SERVICES		
Exam with dilation, as necessary	$5	Up to $30
Retinal imaging[1]	up to $39	Not Covered
Standard contact lens fit and follow-up[2]	Up to $55	Not Covered
Premium contact lens fit and follow-up[2]	10% off retail	Not Covered
FRAMES		
All frames	Up to $150, 20% off balance over $150	Up to $65
LENSES		
Single Vision	$0	Up to $25
Bifocal	$0	Up to $40
Trifocal	$0	Up to $60
Lenticular	$0	Up to $100
LENS OPTIONS[3]		
UV Coating	$15	Not Covered
Tinting (solid and gradient)	$15	Not Covered
Standard scratch resistance	$15	Not Covered
Standard polycarbonate		
› Adult	$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 bifocal)	$15	Up to $40
Premium progressive		
› Tier 1	$110	Not Covered
› Tier 2	$120	Not Covered
› Tier 3	$135	Not Covered
Photocromatic / plastic transitions	$75	Not Covered
Polarized	20% off retail	Not Covered

Optional Benefits Selected
Polycarbonate Lenses for Children < 19 Provides for standard polycarbonate lens
Additional Plan Discounts
Member may receive a 20% discount on items not covered by the plan at network Providers. 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.

Vision Plans

Limitations and Exclusions

Plan limitations and exclusions may vary based on benefits selected. Please see your certificate of coverage for a complete listing of your limitations and exclusions.

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:

    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); or
    c. 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:

    a. War or any act of war, whether declared or not;
    b. Any act of international armed conflict; or
    c. 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 anethesiologist or anesthetist.
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:

    a. Is not a visual necessity;
    b. Does not offer a favorable prognosis;
    c. Does not have uniform professional endorsement; or
    d. 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-inflected injury or bodily illness.
18. Piano lenses
19. Medical or surgical treatment of eye, eyes, or supporting structures
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any vision examination, vision materials.
22. Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this policy.
23. Non-prescription sunglasses except for 20% discount
24. Two pair of glasses in lieu of bifocals
25. Services or materials provided by any other group benefit plans providing vision care.
26. Certain name brands when manufacturer imposes no discount.
27. Corrective vision treatment of an experimental nature
28. Solutions and/or cleaning products for glasses or contact lenses
29. Contact lenses
30. Pathological treatment
31. Non-prescription items
32. Costs associated with securing materials
33. Pre- and Post-operative services
34. Orthokeratology
35. Routine maintenance of materials
36. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
37. Artistically painted lenses