VISION



You may choose from the following vision plans:

- Exam Plus Plan
- Full Service Plan

Humana powered by EyeMed is your vision plan provider. You may choose to cover your family by selecting "Employee & Family" rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

Value-Added Benefits

- Diabetic Eyecare Coverage $0 copay (available only on the Full Service Plan)
- Discounts at ContactsDirect.com
- Discounts at Glasses.com

How Your Vision Plans Work

- After enrolling in your vision plan, you will receive your new Humana vision ID card in the mail.
- Prior to scheduling your appointment, select a participating network provider.
- A list of providers can be found on the Humana website at www.humana.com by simply registering with your member ID number.
- You may contact Humana customer service at 1-877-398-2980, Monday-Saturday 7:30 a.m.-11 p.m. (EST) and 11 a.m. - 8 p.m. Sunday

Humana's Insight network includes top retail names in eye care, LensCrafters, Pearle Vision, Target Optical and most Wal-Mart locations.

Present your Humana Vision card and the Vision provider will do the rest!

Use the Mobile App

Manage your vision care — wherever you are with the MyHumana Mobile app.

- View your plans and coverage details
- View claims
- View, fax or save ID cards
- Find a doctor in your network

Download the Mobile App

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play® or Apple Store®.

Scan Me

To find a provider near you.



Your Tax-Free Vision Rates

EXAM PLUS PLAN	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	$1.46	$1.22	$0.81	$0.73	$0.70	$0.67	$0.61	$0.56
Employee + Family	$3.31	$2.76	$1.84	$1.66	$1.58	$1.51	$1.38	$1.27
FULL SERVICE PLAN	**10-PAY**	**12-PAY**	**18-PAY**	**20-PAY**	**21-PAY**	**22-PAY**	**24-PAY**	**26-PAY**
Employee Only	$8.59	$7.16	$4.77	$4.30	$4.09	$3.91	$3.58	$3.30
Employee + Family	$22.20	$18.50	$12.33	$11.10	$10.57	$10.09	$9.25	$8.54

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

VISION

Partial List of Covered Services

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	EXAM PLUS PLAN		FULL SERVICE PLAN	
	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)
Exam with dilation as necessary • Retinal imaging [1]	$10 Up to $39	Up to $40 Not covered	$20 Up to $39	Up to $40 Not covered
Contact lens exam options [2] • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to $40 10% off retail	Not covered Not covered	Up to $40 $60 copay	Not covered Not covered
Frames [3]	35% off retail	Not covered	$150 allowance 20% off balance over $150	$75 allowance
Standard plastic lenses [4] • Single vision • Bifocal • Trifocal • Lenticular	$50 $70 $105 20% off retail	Not covered Not covered Not covered Not covered	$20 $20 $20 $20	Up to $30 Up to $50 Up to $70 Up to $80
Covered lens options [4] • UV Coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Standard progressive • Polarized	$15 $15 $15 $40 $40 $45 $65 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered	$0 $15 $15 $40 $0 $45 $20 20% off retail	Up to $8 Not Covered Not Covered Not covered Up to $20 Not covered Up to $50 Not covered
• Photochromatic / Plastic transitions • Premium anti-reflective coating Tier 1 | Tier 2 | Tier 3	Not applicable	Not applicable	$75 Premium anti-reflective coatings as follows: $57 | $68 | 80% of charge	Not covered Premium anti-reflective coatings as follows: Not covered
• Premium progressive Tier 1 | Tier 2 | Tier 3 | Tier 4	Not applicable	Not applicable	Premium progressives as follows: $20 | $20 | $20 | $20	Premium progressives as follows: Up to $50 | Up to $50 Up to $50 | Up to $50
Contact lenses [5] **(applies to materials only)** • Conventional • Disposable • Medically necessary	15% off retail Not covered Not covered	Not covered Not covered Not covered	$150 allowance, 15% off balance over $150 $150 allowance $0	$105 allowance $105 allowance $210 allowance

VISION

Partial List of Covered Services

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	EXAM PLUS PLAN		FULL SERVICE PLAN	
	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)
Frequency • Examination • Lenses or contact lenses • Frame	Once every Plan Year Not applicable Not applicable	Once every Plan Year Not applicable Not applicable	Once every Plan Year Once every Plan Year Once every other Plan Year	Once every Plan Year Once every Plan Year Once every other Plan Year
Diabetic Eye Care: care and testing for diabetic members • Examination - Up to (2) services per year	Not covered	Not covered	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	Not covered	Not covered	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	Not covered	Not covered	$0	Up to $15
• Gonioscopy - Up to (2) services per year	Not covered	Not covered	$0	Up to $15
• Scanning Laser - Up to (2) services per year	Not covered	Not covered	$0	Up to $33

Optional benefits

Polycarbonate Lenses for Children <19 — **Provides for standard polycarbonate lens with $0 copay. Not available in AK, CT, ID, & OH.**

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 premium contact lens exam and fit and follow-up cost may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
3 Discounts may be available on all frames except when prohibited by the manufacturer.
4 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
5 Plan covers contact lenses, in lieu of frames, but not both.

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