Humana Dental plans

Arizona

TRADITIONAL PREFERRED

This plan offers low deductible options for preventive, basic, and major services along with the flexibility to see any dentist. With this plan, members receive the same level of coinsurance with all dentists. However, when members choose dentists in the Humana Dental PPO network, they can benefit from our negotiated rates for services received from in-network dentists.

Deductible[1]	Option 1	Option 2	Option 3	Option 4		
Individual	$0	$25	$50	$100		
Family	$0	$75	$150	$300		
Coinsurance	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**	**Option 6**
Preventive services	100%	100%	100%	100%	100%	100%
Basic services	100%	100%	100%	90%	80%	50%
Major services	80%	60%	50%	60%	50%	50%

Plan maximums	
Annual maximum	$500 / $750 / $1,000 / $1,200 / $1,250 / $1,500 / $1,750 / $2,000 / $2,500 / $3,000 / $3,500 / $5,000 / Unlimited
Annual maximum options	• Extended annual maximum: Receive 30% coinsurance for the rest of the year after you reach your annual maximum (orthodontia excluded). • Standard annual maximum
Buy-up options (2+ group sizes)	
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum
Periodontics in Basic services	Moves periodontic services to the Basic services coinsurance amount
Endodontics in Basic services	Moves endodontic services to the Basic services coinsurance amount
Composite fillings for molars	Covers composite fillings on molar teeth at the Basic services coinsurance amount
Orthodontia[2]	Choose Child or Adult/Child coverage Pays 50% (no deductible) for orthodontia services up to a lifetime maximum of (choose one): $1,000 / $1,500 / $2,000 / $2,500
Buy-up options (5+ group sizes)	
Implant placement and services[3]	Covers implant placement and implant crowns, bridges, and dentures at the Major services coinsurance amount

1) Deductible does not apply to preventive services.
2) If you don't choose orthodontia, members may get a discount on non-covered services up to 20 percent if available through their dentist.
3) Implant placement limited to one per tooth every five years including implant crowns, bridges, and dentures.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Dental plans

Arizona

PPO

This plan offers low deductible options for preventive, basic, and major services. In-network dentists provide dental services at a reduced rate. Members have higher out-of-pocket costs for services received from out-of-network dentists.

Deductible[1]	Option 1		Option 2		Option 3		Option 4		Option 5	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Individual	$0	$50	$25	$50	$50	$50	$50	$100	$100	$100
Family	$0	$150	$75	$150	$150	$150	$150	$300	$300	$300

Coinsurance	Option 1		Option 2		Option 3		Option 4	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Preventive services	100%	100%	100%	100%	100%	80%	100%	100%
Basic services	100%	80%	90%	80%	80%	50%	80%	50%
Major services	60%	50%	60%	50%	50%	50%	30%	10%

Plan maximums	
Annual maximum	$500 / $750 / $1,000 / $1,200 / $1,250 / $1,500 / $1,750 / $2,000 / $2,500 / $3,000 / $3,500 / $5,000 / Unlimited
Annual maximum options	• Extended annual maximum: Receive 30% coinsurance for the rest of the year after you reach your annual maximum (orthodontia excluded). • Standard annual maximum
Buy-up options (2+ group sizes)	
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum
Periodontics in Basic services	Moves periodontic services to the Basic services coinsurance amount
Endodontics in Basic services	Moves endodontic services to the Basic services coinsurance amount
Composite fillings for molars	Covers composite fillings on molar teeth at the Basic services coinsurance amount
Orthodontia[2]	Choose Child or Adult/Child coverage Pays 50% (no deductible) for orthodontia services up to a lifetime maximum of (choose one): $1,000 / $1,500 / $2,000 / $2,500
Buy-up options (5+ group sizes)	
Implant placement and services[3]	Covers implant placement and implant crowns, bridges, and dentures at the Major services coinsurance amount

1) Deductible does not apply to preventive services.
2) If you don't choose orthodontia, members may get a discount on non-covered services up to 20 percent if available through their dentist.
3) Implant placement limited to one per tooth every five years including implant crowns, bridges, and dentures.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Dental plans

Arizona

PREVENTIVE PLUS

This plan covers commonly used preventive and basic services, including exams, X-rays, cleanings and fillings. Plus, discounts may be available on additional services like crowns, inlays, oral surgery, and orthodontia.

Deductible[1]	Option 1	Option 2
Individual	$0	$50
Family	$0	$150
Coinsurance	**Option 1**	**Option 2**
Preventive services	100%	100%
Basic services	80%	50%
Major services	Not covered	Not covered

Discount Services (services not covered under the plan, but may be available at a discount through their dentist)

- Additional basic services (crowns, harmful habit appliances for children, oral surgery)
- Major services
- Orthodontia services

Plan maximums	
Annual maximum	$500 / $750 / $1,000
Annual maximum options	• Standard annual maximum (extended annual maximum not available on Preventive Plus plans)

Buy-up options (2+ group sizes)	
Waive preventive from annual maximum	Waives preventive services from accumulating to the annual maximum
Composite fillings for molars	Covers composite fillings on molar teeth at the Basic services coinsurance amount

1) Deductible does not apply to preventive services.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Dental plans

Arizona

ELIGIBILITY

Traditional Preferred, PPO, and Preventive Plus (2+ eligible employees)

Funding Options[1]	
Employer sponsored *(50% participation required)*	
Voluntary	
Administrative Services Only (ASO)[2] *(Limited to 100+ size groups)*	
Enrollment Options[3]	
Open enrollment	Employees without a qualifying event can only join during the annual open enrollment period (waiting periods may apply)
Late applicants	Employees can join at any time during the plan year with or without a qualifying event. (waiting periods may apply)

WAITING PERIODS[4]

Traditional Preferred, PPO, and Preventive Plus (2+ eligible employees)

- Most services in your plan are reimbursed as of the effective date.
- No waiting periods for preventive services.
- No waiting periods for endodontics or periodontics except for late applicants.
- In some circumstances, benefits are available after 12 or 24 months of continual enrollment:

Enrollment Type[5]	Group Size	Preventive	Basic	Major[6]	Orthodontia[6]
Initial enrollment, open enrollment, and timely add-on	Employer sponsored 2-4 enrolled	No	No	12 months	24 months
	Employer sponsored 5+ enrolled	No	No	No	No
	Voluntary 2-9 enrolled	No	No	12 months	24 months
	Voluntary 10+ enrolled	No	No	No	12 months

1) Multiple product options may be offered for groups of 10 or more.
2) Administrative Services Only (ASO) not an available funding option for prepaid plans.
3) If you don't choose an option, open enrollment will apply.
4) The waiting period may be decreased or waived based on the number of months the member had dental coverage immediately before joining the Humana dental plan. Members must have prior orthodontia coverage to reduce or waive the waiting period under orthodontia.
5) Late applicant enrollment will have the following waiting periods: 12 months basic & major services, 12 months orthodontia (24 months for 2-9 enrolled employees).
6) Preventive Plus plans do not cover major and orthodontia services.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Vision plans

Arizona

VISION

Vision plans offer a comprehensive eye exam every year for a low cost. Members receive benefits for glasses or contact lenses without ever paying full retail prices at in-network locations.

	Exams	Frames[1]	Standard Plastic Lenses[2]				Contact Lenses[3]		
	Routine exam with dilation	Frame allowance	Single	Bifocal	Trifocal	Lenticular	Disposable allowance	Conventional allowance[4]	Medically necessary
Vision 100									
In-network provider	$10	$100	$25	$25	$25	$25	$100	$100	$0
Out-of-network provider	Up to $30	$50	Up to $25	Up to $40	Up to $60	Up to $100	$80	$80	Up to $200
Vision 130									
In-network provider	$10	$130	$15 / $25	$15 / $25	$15 / $25	$15 / $25	$130	$130	$0
Out-of-network provider	Up to $30	$65	Up to $25	Up to $40	Up to $60	Up to $100	$104	$104	Up to $200
Vision 150									
In-network provider	$10	$150	$10 / $25	$10 / $25	$10 / $25	$10 / $25	$150	$150	$0
Out-of-network provider	Up to $30	$80	Up to $25	Up to $40	Up to $60	Up to $100	$128	$128	Up to $210
Vision 160									
In-network provider	$10	$160	$10	$10	$10	$10	$160	$160	$0
Out-of-network provider	Up to $30	$80	Up to $25	Up to $40	Up to $60	Up to $100	$128	$128	Up to $210
Vision 200									
In-network provider	$0	$200	$0 / $20	$0 / $20	$0 / $20	$0 / $20	$200	$200	$0
Out-of-network provider	Up to $30	$100	Up to $25	Up to $40	Up to $60	Up to $100	$160	$160	Up to $210

1) Members may receive up to a 20 percent discount on remaining balance after frame allowance when using an in-network provider. Contact provider to determine what discounts are available.
2) Any standard plastic lenses benefit containing two values separated by a (/) represents two copay options available on the plan.
3) Plan covers contact lenses or lenses for frames, but not both, unless you have the Eye Glass and Contact Lens Rider.
4) Members may receive up to a 15 percent discount on remaining balance after conventional contact lens allowance when using an in-network provider. Contact provider to determine what discounts are available.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Vision plans

Arizona

VISION PLUS

These plans offer a comprehensive eye exam every year for a low cost. Members receive benefits for glasses or contact lenses without ever paying full retail prices at in-network locations. This is a tiered network product, where members have access to enhanced benefits at designated PLUS providers, a subset of the Insight network.

	Exams	Frames[1]	Standard Plastic Lenses[2]				Contact Lenses[3]		
	Routine exam with dilation	Frame allowance	Single	Bifocal	Trifocal	Lenticular	Disposable allowance	Conventional allowance[4]	Medically necessary
Vision 100									
In-network PLUS provider	**$0**	**$150**	$25	$25	$25	$25	$100	$100	$0
In-network provider	$10	$100	$25	$25	$25	$25	$100	$100	$0
Out-of-network provider	Up to $30	$50	Up to $25	Up to $40	Up to $60	Up to $100	$80	$80	Up to $200
Vision 130									
In-network PLUS provider	**$0**	**$180**	$15 / $25	$15 / $25	$15 / $25	$15 / $25	$130	$130	$0
In-network provider	$10	$130	$15 / $25	$15 / $25	$15 / $25	$15 / $25	$130	$130	$0
Out-of-network provider	Up to $30	$65	Up to $25	Up to $40	Up to $60	Up to $100	$104	$104	Up to $200
Vision 150									
In-network PLUS provider	**$0**	**$200**	$10 / $25	$10 / $25	$10 / $25	$10 / $25	$150	$150	$0
In-network provider	$10	$150	$10 / $25	$10 / $25	$10 / $25	$10 / $25	$150	$150	$0
Out-of-network provider	Up to $30	$80	Up to $25	Up to $40	Up to $60	Up to $100	$128	$128	Up to $210
Vision 160									
In-network PLUS provider	**$0**	**$210**	$10	$10	$10	$10	$160	$160	$0
In-network provider	$10	$160	$10	$10	$10	$10	$160	$160	$0
Out-of-network provider	Up to $30	$80	Up to $25	Up to $40	Up to $60	Up to $100	$128	$128	Up to $210
Vision 200									
In-network PLUS provider	**$0**	**$250**	$0 / $20	$0 / $20	$0 / $20	$0 / $20	$200	$200	$0
In-network provider	$0	$200	$0 / $20	$0 / $20	$0 / $20	$0 / $20	$200	$200	$0
Out-of-network provider	Up to $30	$100	Up to $25	Up to $40	Up to $60	Up to $100	$160	$160	Up to $210

1) Members may receive up to a 20 percent discount on remaining balance after frame allowance when using an in-network provider. Contact provider to determine what discounts are available.
2) Any standard plastic lenses benefit containing two values separated by a (/) represents two copay options available on the plan.
3) Plan covers contact lenses or lenses for frames, but not both, unless you have the Eye Glass and Contact Lens Rider.
4) Members may receive up to a 15 percent discount on remaining balance after conventional contact lens allowance when using an in-network provider. Contact provider to determine what discounts are available.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Vision plans

Arizona

MATERIALS ONLY

Materials Only plans are limited to coverage for frames, lenses and contact lenses; ideal for clients who have an eye exam included in their medical benefits.

	Exams	Frames[1]	Standard Plastic Lenses				Contact Lenses[2]		
	Routine exam with dilation	Frame allowance	Single	Bifocal	Trifocal	Lenticular	Disposable allowance	Conventional allowance[3]	Medically necessary
Vision 130									
In-network provider	Not covered	$130	$15	$15	$15	$15	$130	$130	$0
Out-of-network provider	Not covered	$65	Up to $25	Up to $40	Up to $60	Up to $100	$104	$104	Up to $200
Vision 160									
In-network provider	Not covered	$160	$10	$10	$10	$10	$160	$160	$0
Out-of-network provider	Not covered	$80	Up to $25	Up to $40	Up to $60	Up to $100	$128	$128	Up to $210

EXAM PLUS

The Exam Plus plan offers an annual comprehensive eye examination for a $10 cost, as well as discounts on frames and other services when using in-network providers.

	Exams	Frames	Standard Plastic Lenses				Contact Lenses		
	Routine exam with dilation	Frame allowance	Single	Bifocal	Trifocal	Lenticular	Disposable allowance	Conventional allowance	Medically necessary
Vision 130									
In-network provider	$10	Not Covered	Not Covered				Not Covered		
Out-of-network provider	Up to $30	Not Covered	Not Covered				Not Covered		

1) Members may receive up to a 20 percent discount on remaining balance after frame allowance when using an in-network provider. Contact provider to determine what discounts are available.
2) Plan covers contact lenses or lenses for frames, but not both, unless you have the Eye Glass and Contact Lens Rider.
3) Members may receive up to a 15 percent discount on remaining balance after conventional contact lens allowance when using an in-network provider. Contact provider to determine what discounts are available.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

Humana Vision plans

Arizona

ADDITIONAL PLAN DETAILS

Benefit frequencies	
Exam[1]	Once every 12 months
Lenses or contact lenses[2]	Once every 12 months
Frames[2]	Once every 24 months
Optional Benefits[3]	
12-month frame benefit	Benefit replaces the 24-month frequency of the base plan
Retinal imaging[4]	$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
Eyeglass and contact lens benefit	Allows fulfillment of frame plus spectacle lenses in addition to the contact lens benefit of the base plan (not available for groups < 100)
Polycarbonate for children <19[5]	Provides for standard polycarbonate lens with $0 copay

VISION PLAN DISCOUNTS

Discount Type	Details
Members 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. • 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 may receive 20% off the retail price.
Lasik & PRK	• 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) Not covered on Materials Only 130 and 160 plans.
2) Not covered on Exam Plus plan.
3) Optional Benefits not available on Exam Plus plan.
4) Not available on Materials Only 130 and 160 plans.
5) Not applicable to Vision PLUS plans. Polycarbonate for children <19 is included in the base benefits.

A full list of plan limitations & exclusions can be found beginning on page 9 of this document

LIMITATIONS & EXCLUSIONS

Our benefit plans have limitations and exclusions and may have waiting periods and terms under which the coverage may be continued in force or discontinued. For costs and complete details of coverage, call or write your Humana insurance agent or broker.

Before applying for group coverage, please refer to the pre-enrollment disclosures for a description of plan provisions, which may exclude, limit, reduce, modify or terminate your coverage. These disclosures are available at **https://www.Humana.com/insurance-through-employer/enrollment-center/pre-enrollment-disclosure** or through your sales representative.

DENTAL LIMITATIONS & EXCLUSIONS

Depending on the plan selected, these Limitations & Exclusions may or may not apply.

- Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
- Services:
  - 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;
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare, or Medicaid); or
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- 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.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
  - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
  - Any service to correct congenital malformation;
  - Any service performed primarily to improved appearance;
  - Characterizations and personalization of prosthetic devices; or
  - Any procedure to change the spacing and/or shape of the teeth.
- Charges for:
  - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
  - Precision or semi-precision attachments;
  - Overdentures and any endodontic treatment associated with overdentures;
  - Other customized attachments;
  - Any service for 3D imaging (cone beam images);
  - Temporary and interim dental services;
  - Additional charges related to material or equipment used in the delivery of dental care;
  - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the policyholder;
  - The removal of any implants unless specified in the Summary of Your Benefits section of the certificate.

- Any service related to:
  - Altering vertical dimension of teeth;
  - Restoration or maintenance of occlusion;
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
  - Bite registration or bite analysis.
- Infection control, including but not limited to sterilization techniques.
- Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in Your Plan Benefits.
- Any service that:
  - Is not eligible for benefits based upon clinical review;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.
- Orthodontic services unless specified in the Summary of Your Benefits section of the certificate. Only the services specified in the plan.
- Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of Benefits).
- Charges exceeding the reimbursement limit for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- Temporary dental services.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
  - Any services for orthognathic surgery;
  - Any services for destruction of lesions by any method;
  - Any services for tooth transplantation;
  - Any services for removal of a foreign body from the oral tissue or bone;
  - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
  - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services. General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
  - Pain control unless a documented allergy to local anesthetic is provided;
  - Anxiety;
  - Fear of pain;
  - Pain management;
  - Emotional inability to undergo surgery.

- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced, or duplicate major restoration, prosthesis or appliance. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre-and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in this certificate.
- Excess coverage:

  - We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or deductibles for the year

VISION LIMITATIONS & EXCLUSIONS

Depending on the plan selected, these Limitations & Exclusions may or may not apply.

- Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
- Services:
  - 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;
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare, or Medicaid); or
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- 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.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in Your Plan Benefits.
- Any service that:
  - Is not eligible for benefits based upon clinical review;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional acceptance; or
  - Is deemed to be experimental or investigational in nature.
- Orthoptic or vision training.
- Subnormal vision aids and associated testing.
- Aniseikonic lenses.
- Any service we consider cosmetic.
- Any expense incurred before your effective date or after the date your coverage under this policy terminates.
- Charges exceeding the reimbursement limit for the service.

- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Plano lenses.
- Medical or surgical treatment of eye, eyes, or supporting structures.
- Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
- Any examination or material required by an Employer as a condition of employment.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plans providing vision care.
- Certain name brands when manufacturer imposes no discount.
- Corrective vision treatment of an experimental nature.
- Solutions and/or cleaning products for glasses or contact lenses.
- Pathological treatment.
- Non-prescription items.
- Costs associated with securing materials.
- Pre- and Post-operative services.
- Orthokeratology.
- Routine maintenance of materials.
- Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
- Artistically painted lenses.

Dental plans insured or administered by Humana Insurance Company.

Vision plans insured by Humana Insurance Company.

This material is provided for informational use only and should not be construed as medical, legal, financial, or other professional advice or used in place of consulting a licensed professional.

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.

Humana®

Policy numbers: GN-70090-HC 1/14 et. al., GN-70148-01 9/15 et. al.