# Humana Vision PLUS

**Individual Vision**

Colorado

## About your plan

Humana knows that good vision health is important to overall health. That's why we're committed to making sure that members get the most value from their vision benefit.

Having your eyes checked every year can help detect vision-related complications, including glaucoma, cataracts, and diabetic retinopathy – the leading cause of blindness among adults[1] and the most common eye complication in diabetic patients[2].

With the Humana Vision PLUS plan, members have access to America's largest vision network[*], with optometrists and ophthalmologists at more than 214,000 access points[†], including both independent and national retail locations such as LensCrafters®, Pearle Vision®, and Target Optical®. Visit **Humana.com/FindCare** to find a network provider near you.

Staying in-network helps you save money on eye exams, frames and lenses, and visiting a designated PLUS Provider will save you even more. Since PLUS Providers are already in our vision network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

You also have access to exclusive, member-only special offers and discounts to use above and beyond your vision benefit; they are not part of the insurance plan. Please contact your provider or see the online provider locator to determine which participating providers have agreed to the discounted rate. New offers are added often, so have a look before scheduling your next eye exam.

**Who can enroll in this plan –** Anyone can enroll in this plan.

## How your plan works

As a member of the Humana Vision PLUS plan, you can:

- Use the on-line provider locator to find a network eye care provider at **Humana.com/FindCare**.
- Purchase eyewear and contact lenses at the provider's office or on-line with a valid prescription.
- Stay in-network to lower your out-of-pocket costs, and your in-network provider will handle the claims paperwork.
- Visit an in-network PLUS provider to receive additional benefits[‡]

This plan has no waiting periods.

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| Vision care services | PLUS In-network | In-network | Out-of-network |
|---|---|---|---|
| **Exam** (One every 12 months from the last date of service) | | | |
| • Exam‡ | $0 copay | $10 copay | $30 allowance |
| • Retinal imaging | $39 | $39 | Not covered |
| **Contact lens exam options** (One every 12 months from the last date of service) | | | |
| • Standard contact lens fit and follow-up | $0 copay | $0 copay | Not covered |
| • Premium contact lens fit and follow-up | 10% off retail price | 10% off retail price | Not covered |
| **Frames** (One every 12 months from the last date of service) | | | |
| • Frames‡ | $0 copay<br>$250 allowance (20% off balance over $250) | $0 copay<br>$200 allowance (20% off balance over $200) | $200 allowance |
| **Lens options** (One every 12 months from the last date of service) | | | |
| • Single vision | $10 copay | $10 copay | $25 allowance |
| • Bifocal | $10 copay | $10 copay | $40 allowance |
| • Trifocal | $10 copay | $10 copay | $55 allowance |
| • Lenticular | 20% off retail price | 20% off retail price | Not covered |
| • Progressive lenses - standard (add-on to bifocal) | $65 copay | $65 copay | $65 allowance |
| • Progressive lenses - tier 1 | $100 | $100 | Not covered |
| • Progressive lenses - tier 2 | $110 | $110 | Not covered |
| • Progressive lenses - tier 3 | $125 | $125 | Not covered |
| • Progressive lenses - tier 4[3] | $90; 20% off retail price less $120 allowance | $90; 20% off retail price less $120 allowance | Not covered |
| • Anti-reflective coating – standard | $25 | $25 | Not covered |
| • Anti-reflective coating – premium tier 1 | $25 | $25 | Not covered |
| • Anti-reflective coating – premium tier 2 | $68 | $68 | Not covered |
| • Anti-reflective coating – premium tier 3 | 20% off retail price | 20% off retail price | Not covered |
| • Photochromic – non-glass | $75 | $75 | Not covered |
| • UV coating | $0 | $0 | Not covered |

| Vision care services (continued) | PLUS In-network | In-network | Out-of-network |
|---|---|---|---|
| **Lens options (continued)** (One every 12 months from the last date of service) | | | |
| • Tint (solid and gradient) | $0 | $0 | Not covered |
| • Standard scratch coating – plastic | $0 | $0 | Not covered |
| • Standard polycarbonate – age 19 and older | $20 | $20 | Not covered |
| • Standard polycarbonate – age 18 and younger | $0 | $0 | Not covered |
| • Other add-ons and services | 20% off retail price | 20% off retail price | Not covered |
| **Contact lenses** (In lieu of lenses; one every 12 months from the last date of service)** | | | |
| • Conventional | $200 allowance (15% off balance over $200) | $200 allowance (15% off balance over $200) | $92 allowance |
| • Disposable | $200 allowance | $200 allowance | $92 allowance |
| • Medically Necessary | $0 copay | $0 copay | $200 allowance |
| **Laser vision correction** | | | |
| • Lasik or photorefractive keratectomy (PRK) from U.S. Laser Network | 15% off retail price or 5% off promotional price | 15% off retail price or 5% off promotional price | Not covered |
| **Special offers** | | | |
| • Other | 20% off retail price on items not covered by plan†† | 20% off retail price on items not covered by plan†† | Not covered |

* Based on EyeMed Insight network and analysis of competitors' largest networks via competitor data, 2023.

† Based on Humana network data, last accessed October 2025.

‡ See the PLUS In-network column for enhanced Exam and Frames benefits.

** Plan allows the member to receive either contacts or frame and lens services.

†† Get 40% off a complete second pair of prescription glasses from participating in-network providers. Simply ask your provider, then choose your favorite frames and lenses.

Special offers and discounts are not insurance. These are only available from participating in-network providers and are subject to change without notice.

**Additional details:**

Member may receive a 20% discount on items not covered by the plan at in-network locations. Discount does not apply to provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see our online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

Members may receive a 15% discount off retail price or may receive 5% off any promotional price of Lasik or photorefractive keratectomy (PRK) laser correction procedures. Lasik or PRK correction procedures are provided by the U.S. Laser Network, owned by LCA Vision. Please note that since Lasik and PRK vision correction are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your immediate location, so members should first call **844-608-2020** for the nearest facility and to receive authorization for the discount.

The covered person is responsible for payment of any amounts in excess of the allowance. Allowances provide no remaining balance for future use within the same Benefit Frequency.

**Important to know:** This plan has a minimum one-year initial contract period.

**Footnotes:**

1. “About Common Eye Disorders and Diseases,” Centers for Disease Control and Prevention, last accessed Oct. 6, 2025, https://www.cdc.gov/vision-health/about-eye-disorders

2. “Diabetic Eye Disease Resources,” National Eye Institute, last accessed Oct. 6, 2025, https://www.nei.nih.gov/learn-about-eye-health/outreach-resources/diabetic-eye-disease-resources

3. Tier 4 progressive lens calculation: Multiply retail price by 80%, subtract the $120 allowance, and add $90.

## Limitations and exclusions

This is an outline of the limitations and exclusions for this Humana Vision PLUS plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. In addition to any limitations and exclusions listed in the "Schedule of Policy Benefits" or "Definition" sections, the policy does not provide benefits for the following:

**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 of Benefits (Who Pays What)";
3. The negotiated fee when services are rendered by network providers; or
4. The allowance, as shown in the "Schedule of Benefits (Who Pays What)", when services are rendered by non-network providers.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the "Schedule of Benefits (Who Pays What)".

We will pay only for the basic cost for lenses and frames covered by the Policy. You are responsible for extras selected, including but not limited to the following:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;

**Exclusions** – We will not cover:

1. Orthoptic 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;
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 but not limited 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 of Benefits ( Who Pays What)";
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;

## Limitations and exclusions (continued)

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).

Insured by Humana Insurance Company.

Policy number: CO-71142

Applications are subject to approval. 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. Plans are not available in all states. Plan benefits may vary by state. Refer to the plan documents for complete details of coverage.

Members may receive discounts on services and materials not covered by the plan from network providers. Members should contact their network provider to determine what discounts may be available.

The Network Access Plan, which describes an access plan specific to your network, is available at **Humana.com** or by calling the customer service number found on your Humana Vision ID card and requesting a copy.

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