Humana Vision PLUS

Individual Vision

New Hampshire

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 one of the largest vision networks in the United States*, with optometrists and ophthalmologists at more than 170,000 access points[†], including both independent and national retail locations such as LensCrafters®, Pearle Vision®, and Target Optical®. Visit **Humana.com/Find-Care** 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 on vision-related products and services. The offers and discounts are easily accessible from the plan's website at **Humana.com** and can be used 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.

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/Find-Care**.
- 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 $250 allowance (20% off balance over $250)	$0 copay $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

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)			
• UV coating	$0	$0	Not covered
• 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 the EyeMed Insight network and analysis of competitors' largest networks via Network360 data, 2021.

† Based on Humana network data, last accessed November 2024.

‡ 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.

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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.

Allowance means the maximum amount we will pay for a covered service as shown in the "Schedule of Policy Benefits". The covered person is responsible for payment of any amounts in excess of the allowance. In the event the dollar amount of the covered service is less than the allowance amount shown in the "Schedule of Policy Benefits", then we will only pay up to the actual dollar amount of the covered service.

Important to know: Dental and vision plans, excluding Dental Savings Plus, may have a minimum one-year initial contract period.

Footnotes:

1. "About Common Eye Disorders and Diseases," Centers for Disease Control and Prevention, last accessed Oct. 11, 2024, https://www.cdc.gov/vision-health/about-eye-disorders

2. "Diabetic Eye Disease Resources," National Eye Institute, last accessed Oct. 11, 2024, 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";
3. The negotiated fee when services are rendered by network providers; or
4. The allowance, as shown in the "Schedule", 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.

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. Treatment provided in a government hospital;
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";
15. Broken appointment fees;
16. Any expense arising from completion of forms;
17. Services provided by someone who ordinarily lives in the covered person's home or is a family member;
18. Treatment resulting from any intentionally self-inflicted injury or bodily illness;
19. Certain name brands when the manufacturer does not discount;
20. Costs associated with securing materials;
21. Orthokeratology;

Limitations and exclusions (continued)

22. Routine maintenance of materials;
23. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in this policy; and
24. Medically necessary contacts are not covered for covered persons with a history of corneal or elective refractive surgery (i.e., laser-assisted in-situ keratomileusis (Lasik), photorefractive keratectomy (PRK), radial keratotomy (RK).

Insured by Humana Insurance Company.

Policy number: NH-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.

EyeMed (the Vendor) is a third-party vendor. Humana's contract with the Vendor does not eliminate a member of any obligations under the policy or change the terms of the policy. Participation in a Vendor's program is voluntary. All representations and warranties contained in this marketing material are made solely by the Vendor, not Humana. Humana and the Vendor, including each party's respective affiliates and subsidiaries, are independent, non-affiliated entities. Humana, its parent and affiliates are not liable to members for the negligent provision of services by the Vendor.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

Enclosure: Vision Policy Outline of Coverage

INDEPENDENT PROVIDER NETWORK

LENSCRAFTERS

PEARLE VISION EST. 1961

OPTICAL

HUMANA INSURANCE COMPANY

Administrative Office: 1100 Employers Blvd
Green Bay, WI 54344 Tel. (800) 544-7001

OUTLINE OF COVERAGE FOR INDIVIDUAL VISION POLICY FORM NH-71142

THIS POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

READ YOUR POLICY CAREFULLY! This outline of coverage provides a very brief description of the important features coverage. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This Vision coverage is designed to provide, to persons insured, benefits for covered vision expenses, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the specific Vision benefits described and any additional benefit described below:

Please read this policy to fully understand all terms, conditions, limitations, and exclusions that apply.

Services/Materials	**Frequency**	**PLUS Network Provider**	**Network Provider**	**Non-Network Provider**
Routine Vision Examination (with dilation as necessary)	1 per 12 months from last date of service	$0 copayment	$10 copayment	$30 allowance
Frames	1 per 12 months from last date of service	$250 allowance	$200 allowance	$200 allowance
Standard Plastic Lenses:	1 per 12 months from last date of service			
Single Vision		$10 copayment	$10 copayment	$25 allowance
Bifocal		$10 copayment	$10 copayment	$40 allowance
Trifocal		$10 copayment	$10 copayment	$55 allowance
Progressive Lens Options: Standard Progressive (add on to bifocal)	1 per12 months from last date of service	$65 copayment	$65 copayment	$65 allowance
Contact Lenses (in lieu of Frames & Lenses):	1 per12 months from last date of service			
Conventional		$200 allowance	$200 allowance	$92 allowance
Disposable		$200 allowance	$200 allowance	$92 allowance
Medically necessary		$0 copayment	$0 copayment	$200 allowance
Standard Contact Lens Fit and Follow up	1 per 12 months from last date of service	$0 copayment	$0 copayment	not covered

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A covered person can use either the frame and lens benefit or the contact lens benefit once every 12 months from the last date of service.

Frames - The network provider will show the covered person the frames that this policy covers in full. If a covered person selects a frame that costs more than the amount covered under this policy, the covered person is responsible for the difference in cost. Where the vision exam shows new lenses or frames or both are a visual necessity, benefits for lenses and frames include (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; and (4) proper fitting and adjustments.

Lenses – Where the vision exam shows new lenses or frames or both are a visual necessity, benefits for lenses and frames include (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; and (4) proper fitting and adjustments.

Contact lens materials when medically necessary – We will pay a benefit for one pair of contact lenses under the following circumstances and only if prior authorization from us is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) high ametropia of either +10D or -10D in any meridian; 4) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 5) Diagnosis of Keratoconus supported by medical record documentation consistent with a two line improvement of visual acuity with contact lenses as the treatment of choice; or 6) monocular aphakia and/or binocular aphakia where the provider certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

PLUS Network Providers
When you go to a network provider who is a PLUS network provider you may be eligible for reduced copayments or additional allowance amounts on select services as shown in this Schedule.

Limitations & exclusions: In addition to any limitations and exclusions listed in "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 the policy, shown in the schedule;
3. The negotiated fee when services are rendered by network providers; or
4. The allowance, as shown in the schedule, 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.

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; and
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 the 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 the policy ends;
8. Contact lenses, except as specifically covered by the 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 Medicaid);
    C. Treatment provided in a government hospital;
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;
15. Broken appointment fees;
16. Any expense arising from completion of forms;
17. Services provided by someone who ordinarily lives in the covered person's home or is a family member;
18. Treatment resulting from any intentionally self-inflicted injury or bodily illness;
19. Certain name brands when the manufacturer does not discount;
20. Costs associated with securing materials;
21. Orthokeratology;
22. Routine maintenance of materials;
23. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the policy; and
24. 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).

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Choice of providers: You and your covered dependents have the freedom to choose the provider of choice. However, maximum benefits will be received by seeing a network provider. A non-network provider may balance bill you for any expense incurred that exceeds our reimbursement limit, and some services are not covered when performed by a non-network provider. **Please refer to your Policy and the "Schedule" included with your Policy for full details of your coverage.**

Renewability: You have the right to renew the Policy by paying the required premium by the end of each "Grace Period" subject to the "Termination" section of the Policy.

Premiums: Your premium may change when:
1. Covered persons are added or deleted;
2. Coverage is increased or decreased;
3. A covered person moves to a different zip code or county;
4. Premium payment method is changed;
5. A new rate table applies;
6. Any covered person's age increases;
7. Any covered person's rating classification changes; or
8. A misstatement on the application form results in the proper amount due not being charged.

We will provide you 30 days advance notice of any premium change . Your continued payment of premium will stand as proof of your agreement to the change.

Termination of coverage: Coverage terminates on the earliest of the following events:
1. Termination date of the policy;
2. Failure to pay premium by the required due date, subject to grace period;
3. The end of the month you enter the military fulltime;
4. The end of the month you or a covered person are covered on a group plan;
5. The date a covered person commits fraud or intentional misrepresentation of a material fact, as determined by us;
6. The end of the month you are no longer eligible for coverage;
7. For a dependent, the end of the month he/she no longer meets the definition of a dependent;
8. The receipt of your request or specified date that insurance be terminated for you and/or your dependents;;
9. The end of the month that a change in your legal residence from the state in which the policy was issued occurs;
10. The end of the month you move outside the service area, as determined by us. Call the telephone number on your ID card for the policy's service area.

We may also terminate your coverage with advance notice when:
1. We have a right or defense to take such action by law; or
2. We cease to offer a type of policy or cease to do business in the individual dental insurance market, as allowed by state or federal law.

If coverage under the policy is terminated due to fraud or an intentional misrepresentation of a material fact, a 30-day advance written notice of the termination will be provided.