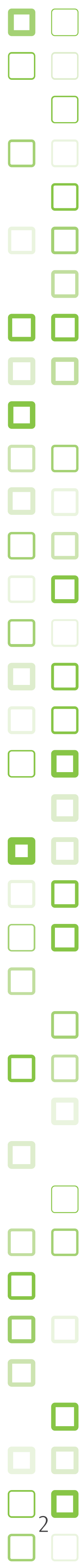
Vision plan

The benefits and services highlighted below provide an overview of the vision plan you can sign up for. The table shows how services will be paid when you visit an eye care professional in the network.

Vision Care Plan (including exam and materials)		
	See a participating provider	**See a nonparticipating provider**
Exam[1] with dilation as necessary	100% after $10 copay	$40 allowance
Lenses		
Single vision	100% after $10 copay	$40 allowance
Bifocal	100% after $10 copay	$60 allowance
Trifocal	100% after $10 copay	$80 allowance
Lens options		Not covered
Standard progressive	100% after $60 copay	
Premium progressive		
• Tier 1	• 100% after $70 copay	
• Tier 2	• 100% after $94 copay	
• Tier 3	• 100% after $135 copay	
• Tier 4	• 100% after $175 copay	
Standard anti-reflective coating	100%	
Premium anti-reflective coating		
• Tier 1	• 100%	
• Tier 2	• 100% after $85 copay	
• Tier 3	• 100% after $105 copay	
UV protection	100% after $15 copay	
Standard scratch resistant coating	100%	
Premium scratch resistant coating	100%	
Frames	$125 wholesale allowance	$100 retail allowance
Contact lenses[2]		
Elective (conventional and disposable)[3]	$150 allowance	$75 allowance
Medically necessary (limit one pair)[4]	100%	$100 allowance
Frequency (based on date of service)		
Examination	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

1. *Material copay is required for a complete pair of eyeglasses, lenses or frames.*
2. *If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).*
3. *The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members may be eligible to receive up to a 15% discount on participating provider professional services. The discount for professional services is available for 12 months after the covered eye exam.*
4. *Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.*



Vision plan

Monthly member rates (People First Benefit Plan Code: 3004)	
Employee only	$5.92
Employee and spouse	$11.68
Employee and child(ren)	$11.56
Employee and family	$18.16

Wholesale frame allowance

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, employees pay twice the wholesale difference. They never pay full retail.

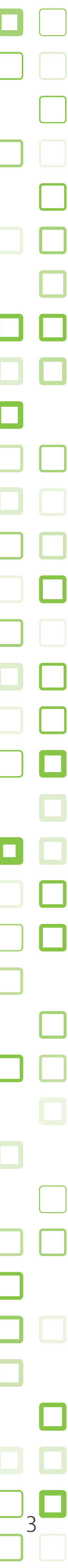
Retail price*	Wholesale price	Wholesale allowance	Member cost	Savings
$150 – $225	$125	$125	$0	$150 – $225
$200 – $300	$150	$125	$50 ($150 –$125=$25x2=$50)	$150 – $250

**Retail costs may differ and are based on two to three times the wholesale cost. Actual savings may vary.*

See the savings with Humana VCP plans:	Retail	Humana Vision In-network providers
Eye Exam	$119	$10
Lenses	$153	$10
Average retail frame cost	$208	$208
Average frame allowance	none	–$125
Discount on balance over frame allowance	none	–20%
YOUR COST:	**$480**	**$86.40**

On average, members save 80% when visiting an in-network provider

Savings example only for illustrative purposes. Actual savings will depend on benefits and frame selection. Retail cost based on industry averages.



Additional plan discounts through participating providers

- Members receive additional fixed copayments on lens options including progressive lens, anti-reflective and polarized styles.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the participating provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate lenses available at no charge for dependents younger than 19 years old.
- Members' $40 scratch-resistant lens allowance covers factory and premium scratch-resistant coatings at no additional payment.
- Members' $70 anti-reflective lens allowance covers standard and premium anti-reflective (AR) coating products at no additional payment.

Humana Vision Lasik discount

We have contracted with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by network providers. Participants receive a 25% discount off the usual and customary price or 5% off advertised promotions or specials for Lasik services provided by in-network providers, whichever discount is greater. The discount includes consultations, laser procedure, follow-up visits and any additional necessary corrective procedures.

Limitations and exclusions

The Vision Care Plan provides a complete analysis of the eyes and related structures to determine vision problems or other abnormalities once every 12 months. The plan covers any lenses needed for the patient's visual welfare as determined by the network doctor. Certain lenses such as those described in the "Limitations" are cosmetic in nature and are not necessary for the visual welfare of the patient. The extra cost of these must be borne by the patient. The plan offers a wide selection of frames every 24 months. The plan covers contact lenses every 12 months. The contact lens allowance replaces the lens and frame benefits, and plan copayments do not apply for the contact lens allowance.

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 of Benefits or
3. The allowance as shown in the Schedule of Benefits. 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.

We will pay only for the basic cost for lenses and frames covered by the policy. The insured is responsible for extras selected, including but not limited to:

1. Blended lenses
2. Progressive multifocal lenses
3. Photochromatic 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; unless otherwise specifically listed as a covered benefit in the Schedule of Benefits

Exclusions

We will not cover:

1. Orthopic 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 eyes
4. Any services and/or materials required by an employer as a condition of employment
5. Any injury or illness covered under any workers' compensation or similar law
6. Sub-normal vision aids, aniseikonic lenses or nonprescription lenses
7. Charges incurred after: (a) the policy ends; or (b) the insured's coverage under the policy ends, except as stated in the policy
8. Experimental or nonconventional treatment or device
9. Contact lenses, except as specifically covered by the policy
10. High index, aspheric and nonaspheric styles
11. Oversized 61 and above lens or lenses
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits