Humana Vision 100
PEARLAND ISD

TEXAS

Services	In-network provider (Member cost)	Out-of-network provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
Retinal imaging*[1]	Up to $39	Not covered
Contact lens exam[2]		
Standard contact lens fit and follow-up*	Up to $40	Not covered
Premium contact lens fit and follow-up*	10% off retail	Not covered
Frames[3]	$100 allowance, 20% off balance over $100	$50 allowance
Standard plastic lenses		
Single vision	$25	Up to $25
Bifocal	$25	Up to $40
Trifocal	$25	Up to $60
Lenticular	$25	Up to $100
Lens options[4]		
UV coating*	$15	Not covered
Tint (solid and gradient)*	$15	Not covered
Standard scratch-resistance*	$15	Not covered
Standard polycarbonate - Adults*	$40	Not covered
Standard polycarbonate - Children <19*	$40	Not covered
Standard anti-reflective coating*	$45	Not covered
Premium anti-reflective coating*		
• Tier 1	$57	Not covered
• Tier 2	$68	Not covered
• Tier 3	20% off retail	Not covered
Standard progressive (add-on to bifocal)	$25	Up to $40
Premium progressive*		
• Tier 1	$110	Not covered
• Tier 2	$120	Not covered
• Tier 3	$135	Not covered
• Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
Photochromatic / Plastic transitions*	$75	Not covered
Polarized*	20% off retail	Not covered

*This service is not a covered benefit under your insurance policy. However, this service may be available to members from participating providers at the discounted rate shown. Members should confirm pricing with their provider.

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Services	In-network provider (Member cost)	Out-of-network provider (Reimbursement)
Contact lenses[5] (applies to materials only)		
Conventional	$120 allowance, 15% off balance over $120	$80 allowance
Disposable	$120 allowance	$80 allowance
Medically necessary	$0	$200 allowance
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Diabetic eye care: Care and testing for diabetic members		
Examination • Up to (2) services per year	$0	Up to $77
Retinal imaging • Up to (2) services per year	$0	Up to $50
Extended Ophthalmoscopy • Up to (2) services per year	$0	Up to $15
Gonioscopy • Up to (2) services per year	$0	Up to $15
Scanning laser • Up to (2) services per year	$0	Up to $33

[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 lens exam fit and follow up costs and premium contact lens exam discounts up to 10% 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 or lenses for frames, but not both.

Optional benefits	
12-month frame benefit	Benefit replaces the 24-month frequency of the base plan.

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TEXAS

Additional plan discounts

- 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. Services or materials provided by any other group benefit plan providing vision care may not be covered. 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.
- 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 specialty trained providers, this discount may not always be available from a provider in your immediate location.

Monthly rates** (12 deductions per year)

Employee:	$7.29
Employee + spouse:	$14.56
Employee + child(ren):	$16.01
Family:	$23.28

**This is not a substitute for a quote. Rates must be approved by Humana Vision underwriting.



Questions?

Visit **Humana.com** or call **877-398-2980**
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a vision provider at **Humana.com/find-care**



Register today!

Register or sign in to MyHumana at **Humana.com** to view your coverage details, ID cards, manage claims, find a vision provider and more!

Limitations and exclusions (all services):

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. 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.
3. 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.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. 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 investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Insured by Humana Insurance Company

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance 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.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana.

Policy Number: TX-70148-01 9/15 et.al.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك