# Humana Vision 130

LOUISIANA

**New Beginnings Schools Foundation**

| Vision care services | If you use an IN-NETWORK provider (Member cost) | If you use an 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 options[2]** | | |
| • Standard contact lens fit and follow-up | Up to $55 | Not covered |
| • Premium contact lens fit and follow-up | 10% off retail | Not covered |
| **Frames[3]** | Up to $130<br>20% off balance over $130 | Up to $65 |
| **Standard plastic lenses[4]** | | |
| • Single vision | $15 | Up to $25 |
| • Bifocal | $15 | Up to $40 |
| • Trifocal | $15 | Up to $60 |
| • Lenticular | $15 | Up to $100 |
| **Covered 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 | Premium anti-reflective coatings as follows: | Premium anti-reflective coatings as follows: |
| - Tier 1 | $57 | Not covered |
| - Tier 2 | $68 | Not covered |
| - Tier 3 | 80% of charge | Not covered |
| • Standard progressive (add-on to bifocal) | $15 | Up to $40 |
| • Premium progressive | Premium progressives as follows: | Premium progressives as follows: |
| - Tier 1 | $110 | Not covered |
| - Tier 2 | $120 | Not covered |
| - Tier 3 | $135 | Not covered |
| - Tier 4 | $90, 80% of charge, then up to $120 | Not covered |
| • Photochromatic / plastic transitions | $75 | Not covered |
| • Polarized | 20% off retail | Not covered |
| **Contact lenses[5]** (applies to materials only) | | |
| • Conventional | Up to $130,<br>15% off balance over $130 | Up to $104 |
| • Disposable | Up to $130 | Up to $104 |
| • Medically necessary | $0 | Up to $200 |

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| Vision care services | If you use an IN-NETWORK provider (Member cost) | If you use an OUT-OF-NETWORK provider (Reimbursement) |
|---|---|---|
| **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 24 months | Once every 24 months |
| **Diabetic Eye Care: care and testing for diabetic members** | | |
| • Examination<br>- Up to (2) services per year | $0 | Up to $77 |
| • Retinal Imaging<br>- Up to (2) services per year | $0 | Up to $50 |
| • Extended Ophthalmoscopy<br>- Up to (2) services per year | $0 | Up to $15 |
| • Gonioscopy<br>- Up to (2) services per year | $0 | Up to $15 |
| • Scanning Laser<br>- 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 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 frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

## Additional plan discounts

- Member 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 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.

## Limitations and Exclusions:

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.

## Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis[1].

[1] Thompson Media Inc.

## Questions

Check out Humana.com

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

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.

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