

| 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 <ul style="list-style-type: none"> Retinal imaging¹ | \$10 Up to \$39 | Up to \$30 Not covered |
| Contact lens exam options² <ul style="list-style-type: none"> Standard contact lens fit and follow-up Premium contact lens fit and follow-up | Up to \$55 10% off retail | Not covered Not covered |
| Frames³ | \$135 allowance 20% off balance over \$135 | \$65 allowance |
| Standard plastic lenses⁴ <ul style="list-style-type: none"> Single vision Bifocal Trifocal Lenticular | \$15 \$15 \$15 \$15 | Up to \$25 Up to \$40 Up to \$60 Up to \$100 |
| Covered lens options⁴ <ul style="list-style-type: none"> UV coating Tint (solid and gradient) Standard scratch-resistance Standard polycarbonate - adults Standard polycarbonate - children <19 Standard anti-reflective coating Premium anti-reflective coating <ul style="list-style-type: none"> Tier 1 Tier 2 Tier 3 Standard progressive (add-on to bifocal) Premium progressive <ul style="list-style-type: none"> Tier 1 Tier 2 Tier 3 Tier 4 Photochromatic / plastic transitions Polarized | \$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90 copay, 80% of charge less \$120 allowance \$75 20% off retail | Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered Not covered |
| Contact lenses⁵ (applies to materials only) <ul style="list-style-type: none"> Conventional Disposable Medically necessary | \$150 allowance, 15% off balance over \$150 \$150 allowance \$0 | \$104 allowance \$104 allowance \$200 allowance |

Humana Vision 130

Vision care services

| | If you use an IN-NETWORK provider (Member cost) | If you use an OUT-OF-NETWORK provider (Reimbursement) |
|--|--|--|
| Frequency <ul style="list-style-type: none"> • Examination • Lenses or contact lenses • Frame | Once every 12 months Once every 12 months Once every 24 months | Once every 12 months Once every 12 months Once every 24 months |
| Diabetic Eye Care: care and testing for diabetic members <ul style="list-style-type: none"> • Examination <ul style="list-style-type: none"> - Up to (2) services per year • Retinal Imaging <ul style="list-style-type: none"> - Up to (2) services per year • Extended Ophthalmoscopy <ul style="list-style-type: none"> - Up to (2) services per year • Gonioscopy <ul style="list-style-type: none"> - Up to (2) services per year • Scanning Laser <ul style="list-style-type: none"> - Up to (2) services per year | \$0 \$0 \$0 \$0 \$0 | Up to \$77 Up to \$50 Up to \$15 Up to \$15 Up to \$33 |

Optional benefits

- Polycarbonate Lenses for Children <19 Provides for standard polycarbonate lens with \$0 copay. Not available in AK, CT, ID, & OH.

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.

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.

Please note that limitations and exclusions can be found in your policy or by contacting ARSEBA.

Provider Search Tool: [Humana Vision Insight Network Provider Search](#)

