VII. VISION INSURANCE
If you select the Humana Specialty Benefits Vision Plan, you receive prepaid services for routine eye care - vision exam plus glasses (lenses and frames) or contacts - through a nationwide network, including more than 1,200 eye doctors in Florida. Or you can visit a non-network doctor and be reimbursed according to plan allowances less applicable copayments. Coverage also is available for your spouse/domestic partner and/or eligible children through payroll deductions.

**PREPAID PLAN BENEFITS**

**Vision Exam:** Your network doctor will do a complete analysis of your eyes and related structures to determine any vision problems or other abnormalities.

**Lenses:** The plan provides the lenses you need for your visual welfare, as determined by your network doctor. Your doctor will order your lenses from an approved optical lab and will verify the accuracy of the finished lenses.

**Frame:** The plan covers a wide range of frames. You can ask your network doctor to show you the frames that the plan covers in full. If you choose a frame that costs more than what the plan covers, you pay the additional charges.

**Contact Lenses:** The plan covers contact lenses, but the extent of coverage depends on whether they are *medically necessary or elective* (i.e., you choose them because you prefer them).

**Medically necessary lenses:** The plan fully covers contact lenses if they are pre-authorized in any of these instances:

- After cataract surgery
- To correct extreme visual acuity problems that cannot be corrected to 20/70 with eyeglasses
- Certain conditions of anisometropia and keratoconus

Your doctor may determine that you need contact lenses due to other conditions. If so, the doctor can ask Humana Specialty Benefits Vision Plan for prior approval. If the Plan approves the request, it will fully cover your contact lenses if you get them from a network doctor.

**Elective lenses:** When you choose contacts instead of glasses, the plan pays a flat benefit of $125 toward the *combined* value of your:

- Fitting Fees
- Contact lenses
- Any follow-up visits

The elective contact lens allowance replaces all other benefits. You can choose either the examination, subject to the copayment, and the $125 allowance *or* the other covered services (exam and glasses), but not both.

**LASIK VISION CORRECTION**

**Reduced fees:** Lasik procedures are available if you are nearsighted or have astigmatism and wear glasses or contacts. We have contracted with many well-known facilities and eye doctors to offer these procedures at substantially reduced fees.

You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):
**Network Location** | **Conventional/Traditional** | **Custom**
---|---|---
TLC<br>888-358-3937<br>Designated locations only | $895 | $1,295 $1,895* 
**LasikPlus**<br>866-757-8082<br>Free enhancements<br>for 1 year | $695*<br>LasikPlus<br>Free enhancements<br>for life | $1,395*<br>LasikPlus<br>Free enhancements<br>for life | $1,895*<br>LasikPlus<br>Free enhancements for life 
**QualSight LASIK**<br>855-456-2020<br>Free enhancements<br>for 1 year | $895<br>QualSight<br>Free enhancements<br>for 1 year | $1,295<br>with QualSight<br>Lifetime Assurance<br>Plan | $1,320<br>with QualSight<br>Lifetime Assurance<br>Plan

*with IntraLase™

You can also use independent Lasik provider network doctors to receive a 10% discount from usual and customary prices and pay no more than $1,800 per eye for Conventional Lasik and $2,300 per eye for Custom Lasik. Your ID card verifies your eligibility for Lasik discounts. You can obtain a list of providers from our website or by calling 866-537-0229.

**PLAN COPAYMENTS**
Vision exam $5 
Lenses and/or frame $15

**FREQUENCY OF BENEFITS**
Plan services and materials are available according to this timetable:
- Eye exam Every 12 months
- Lenses Every 12 months
- Frames Every 12 months

**DUAL CHOICE**
This is a “dual choice” plan. This means you can choose a network or non-network doctor. How much you pay for covered services and materials depends on whether or not you use a network doctor. Services under the non-network reimbursement schedule are subject to the same timetable and copayments as those for network services. (The copayments do not apply to the elective contact lens allowance.)

This chart shows network and non-network maximum allowances:

<table>
<thead>
<tr>
<th>Network Doctor (up to plan limits, less copayments)</th>
<th>Non-Network Doctor (maximum reimbursement, less copayments)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong>*</td>
<td>Paid in Full</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong> (per pair)</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>Single</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Paid in Full</td>
</tr>
</tbody>
</table>

No charge for Polycarbonate lenses for children <19 years of age

**Over 200 different Lens Options are available at a copayment.**
Examples of some popular options:
- **Polycarbonate Lenses**** $28/$32 (Shatterproof with a UV coat)
- **Photochromic/Transitions**** $77-116 (Lenses turn darker in sunlight)
- **Progressives*** $60-$270 (Various levels)
- **Scratch Resistant**** $16/$53 (Anti-Scratch Coating)
- **UV Protection** $15 (Ultra-Violet Protection)
Anti-Reflective Coatings** $44-$130 (Light Reflecting Coating)

The above list is not a complete list of lens option benefits. A COMPLETE MEMBER LENS OPTIONS PRICE LIST IS AVAILABLE UPON REQUEST.

<table>
<thead>
<tr>
<th>Frame</th>
<th>Contact Lenses</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$50 wholesale allowance</td>
</tr>
<tr>
<td></td>
<td><strong>Contact Lenses</strong></td>
</tr>
<tr>
<td></td>
<td>Elective (Fitting + lenses)*****</td>
</tr>
<tr>
<td></td>
<td>Medically necessary****</td>
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</table>

*Complete vision exam per Department of Professional Regulation rule 21Q-3.07.

**Copays shown are based on single/multi-focal lenses.

***Progressive copays shown are a range and vary based on the level.

**** One pair of contact lenses are covered when medically necessary after cataract surgery, or when visual acuity cannot be corrected to 20/70, or due to other medical conditions, prior authorization required.

*****The elective contact lens allowance is paid when a prescription change is warranted, and with the same frequency as eyeglass lenses. The plan pays the contact lens allowance in place of all other benefits.

** HOW TO USE THIS PLAN **

Network doctor: Using a network doctor assures quality and cost control, and direct payment to the doctor. When you use a network doctor (as do 97% of all plan members), you’ll show your ID card and pay your plan copayments at the time of your visit. You pay nothing more except the cost of any upgrades or cosmetic extras you choose. By using a network doctor you will receive additional value-added extras, such as a 20% discount on a second pair of eyeglasses and/or a 15% discount on professional service fees for elective contact lenses (fittings). These extras are available for 12 months after the covered eye exam from the Humana Specialty Benefits Vision Plan network doctor who performs that initial exam.

Out-of-state network services: Humana Specialty Benefits Vision Plan services are available nationwide through a network of thousands of doctors. If you travel, or if a covered family member moves to another state (for example, a child away at college), the plan provides the same benefits as long as that plan member is eligible. You can view providers on Humana’s website at www.humanavisioncare.com.

Non-network doctor: If you see a non-network doctor, the plan pays non-network benefits in place of services you would have received from a network doctor less applicable copayments. When you use a non-network doctor, you pay that doctor’s regular charges at the time of your visit. Then send your itemized receipts with Humana’s one page claim form to the plan for reimbursement according to the schedule of benefit allowances on page 2. The actual benefit amount the plan will reimburse you will be the lowest of the maximum shown in the schedule; the amount actually charged; or the amount a doctor usually charges a private patient. You should know that there is no guarantee that scheduled benefit amounts will be enough to fully pay for your eye exam or glasses. Reimbursement benefits are not assignable.

Dependent– means any of the following persons:
1) your spouse/domestic partner;
2) your child;
   a) from birth through the end of the calendar year in which the child attains the age of 26;
   b) at least 26 years of age and;
      i. primarily dependent upon you for support because of mental or physical handicap;
      ii. was incapacitated and insured under Policy on his 26th birthday; and
      iii. continues to be incapacitated beyond his 26th birthday.

A child also includes adopted children, children of a domestic partner, as well as stepchildren, children placed in court-ordered custody, including foster children, living with you in a parent-child relationship.
LIMITATIONS

Extra costs: The plan is designed to cover your visual needs, but not cosmetic choices. If you choose any of the following items there will be extra charges that you must pay. These items include:

- Oversized, coated or faceted lenses
- Blended or progressive lenses
- Tinted or photochromic lenses (except pink #1 and #2)
- A frame that costs more than the plan allowance
- Other cosmetic items

Not covered: The plan does not pay benefits for services or materials connected with:

- Orthoptics or vision training
- Subnormal vision aids, aniseikonic lenses or non-prescription (plano) lenses
- Replacing lost or broken lenses and frames you received from the plan (except at the scheduled times when your plan services are otherwise available)
- Medical or surgical eye treatment
- Services or materials provided by Workers’ Compensation or any government program
- Any eye exam required by an employer as a condition of employment
- Service or material provided by another group plan with vision benefits
- Two pairs of glasses instead of bifocals

Coordination of benefits: This plan will coordinate benefits with other vision coverage you may have (e.g., through your spouse’s/domestic partner’s employer) so that your benefits from all plans do not exceed 100% of your allowable expenses. The order of benefit determination follows National Association of Insurance Commissioners (NAIC) rules.

WHEN COVERAGE ENDS

Your vision coverage ends when you are no longer eligible, or when the plan ends. Benefits end on your last day of coverage, unless you qualify for extended benefits.

Extension of benefits: If you’re an eligible plan member receiving services and/or benefits on the date your coverage ends, service will continue to completion, but not beyond nine months after the date your coverage ends.

Continuation of coverage: You can continue your group coverage to an individual vision policy if you were covered by this plan for at least 3 straight months, and your coverage ends because your employment ends, or a reduction in hours makes you ineligible for the plan. Covered family members may continue coverage if they are no longer eligible because your marriage ends, you die, or a child reaches the age limit or no longer qualifies as a dependent. Coverage may continue through COBRA and/or conversion to an individual policy. Check with the Insurance Benefits Section for details.