Humana Dental & Vision

NEW Humana Dental and Vision Plans/Rates are Guaranteed 1/1/2019 - 12/31/2020

NEW! Your MSA Pro Membership now unlocks your access to enroll your employees in select Dental and Vision plans with Humana!

Humana Dental and Vision Product Guide

Healthy employees are good for business. They're more productive, miss fewer days of work and help you control healthcare costs.

MSA helps you achieve a healthier bottom line by focusing on your employee Dental and Vision needs.

Please see the back page of this flyer to view your NEW dental and vision options.

Humana.

1 Identify your region (the state of the employers main location)

Dental & Vision Rating Regions	
Region 1	AL, KS, KY, LA, MO, MS, NE, OH, OK, PA, TN & WV
Region 2	AR, AZ, CO, DC, DE, FL, GA, IA, IL, IN, MD, MI, MN, NC, NV, SC, TX, UT, VA & WI
Region 3	AK, CA, CT, HI, ID, MA, ME, MT, ND, NH, NJ, NM, NY, OR, RI, SD, VT, WA & WY

2 Choose the Humana Dental Plan that best meets your needs. Rates by region are listed below.

HUMANA DENTAL PLAN OPTIONS

BENEFITS	Dental Option (PPO) - Premium Plan- IN	OUT	Dental Option (TRP) -Enhanced Plan- IN	OUT	BENEFITS	Dental Option (Prev Plus) -Value Plan- IN	OUT
Preventive 2 Routine Oral Exams & Cleanings Per Year, Bitewing X-rays, Oral Cancer Screenings (ages 40 and older), Kids flouride treatment/sealants/space maintainers (through age 14)	100%	100%	100%	100%	Preventive & Diagnostic 2 Routine Oral Exams & Cleanings Per Year, Bitewing X-rays, Oral Cancer Screenings (ages 40 and older), Kids flouride treatment/sealants/space maintainers (through age 14)	100%	100%
Basic Emergency Care for Pain Relief, Amalgam (silver) and Composite (tooth colored) Fillings, Oral Surgery, Stainless Steel Crowns, Endodontics (Root Canals), Harmful Habit Appliances for Kids (through age 14)	90%	80%	80%	80%	Basic (oral surgery) Emergency Care for Pain Relief, Amalgam (silver) fillings, Composite (tooth colored) Fillings for antior (front) teeth only, Oral Surgery (routine extractions)	50%	50%
Major Crowns, Inlays/Onlays, Bridges, Dentures, Denture Relines/Rebases, Denture Repair and Adjustments, Implants, Periodontic (deep gum) cleanings (4 per year)	60%	50%	50%	50%	Major These services are not covered under this plan. Members may receive a discount on non-covered services and may contact their participating provider to determine if any discounts are available.	0%	0%
Orthodontics These services are not covered under this plan. Members may receive a discount on non-covered services of up to 20%. Please contact your provider to inquire.	N/A		N/A		Orthodontics These services are not covered under this plan. Members may receive a discount on non-covered services. Please contact your provider to inquire.	N/A	
DEDUCTIBLE Applies to all services EXCEPT Preventive.					DEDUCTIBLE Applies to all services EXCEPT Preventive.		
Individual	**$ 50**	**$ 50**	**$ 50**	**$ 50**	**Individual**	**$ 50**	**$ 50**
Family	**$ 150**	**$ 150**	**$ 150**	**$ 150**	**Family**	**$ 150**	**$ 150**
MAXIMUMS					MAXIMUMS		
Calendar Year Annual Max	**$1,500**		**$1,000**		**Calendar Year Annual Max**	**$1,000**	
Extended Annual Max This benefit helps members save money by ensuring they have access to **Network Discounts** AND **30% Coinsurance**, after reaching their annual max. This is available to **all members day one** and there is **no cap**!	**Yes**		**Yes**		**Extended Annual Max**	**N/A**	
Out-of-Network	**90th**		**90th**		**Out-of-Network**	**90th**	

	MONTHLY RATES			MONTHLY RATES				MONTHLY RATES		
COVERAGE LEVEL	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3	COVERAGE LEVEL	Region 1	Region 2	Region 3
Employee Only	$ 34.19	$ 40.22	$ 52.59	$ 30.01	$ 35.30	$ 45.89	Employee Only	$ 11.14	$ 13.10	$ 17.03
Employee + Spouse	$ 68.39	$ 80.46	$ 104.59	$ 60.00	$ 70.59	$ 91.77	Employee + Spouse	$ 25.23	$ 29.68	$ 38.59
Employee + Child(ren)	$ 87.20	$ 102.58	$ 133.36	$ 76.51	$ 90.01	$ 117.01	Employee + Child(ren)	$ 29.61	$ 34.83	$ 45.28
Employee + Family	$ 121.39	$ 142.81	$ 185.65	$ 106.51	$ 125.31	$ 162.90	Employee + Family	$ 46.62	$ 54.84	$ 71.30

3 Choose the Humana Vision Plan that best meets your needs. Vision rates are the same for ALL regions.

HUMANA VISION PLAN OPTIONS

BENEFITS	Vision Option (160) - Premium Plan - IN	OUT	Vision Option (130) -Enhanced Plan- IN	OUT
Exam With Dialation	$10	Up to $30	$10	Up to $30
-Retinal Imaging	Up to $39	N/A	Up to $39	N/A
Contact Lens Exam (standard)	$0	Up to $30	Up to $55	N/A
Frame Allowance	$160	$80 allowance	$130	$65 allowance
Standard Plastic Lenses -Single/Bifocal/Trifocal/Lenticular	$10	Up to $25/$40/$60/$100	$15	Up to $25/$40/$60/$100
Standard Progressives	$10		$15	Up to $40
Premium Progressives -Tier 1/Tier 2/Tier 3/Tier 4	$45/$55/$70/$25 copay & 80% - $120 allow	Up to $40 each	$110/$120/$135/$90 copay, 80% - $120 allow	N/A
Contact lenses	$160	$128 allowance	$130	$104 allowance
Frequency				
Exam/Lenses or Contacts/Frame	1x 12 months	1x 12 months	1x 12 months	1x 12 months
Diabetic Eye Care Benefit	Included	Allowance	Included	Allowance
COVERAGE LEVEL	MONTHLY RATES		MONTHLY RATES	
Employee Only	$ 12.46		$ 8.31	
Employee + Spouse	$ 24.92		$ 16.61	
Employee + Child(ren)	$ 26.07		$ 18.18	
Employee + Family	$ 39.61		$ 27.20	

These exhibits are for illustration purposes only. Please see Humana's benefit summaries for complete details.

Underwriting Guidelines:
- You must be a **MSA Pro member** to qualify for these plans and rates.
- **No employer contribution is required**. Plans can be offered to your employees on a voluntary basis.
- There are **no waiting periods** for timely enrollments.
- A **minimum of 2 employees** must enroll in dental.
- If **vision and dental are sold together**, a **minimum of 2 employees** must enroll in vision. If **vision is sold without dental** then a **minimum of 5 employees** must enroll in vision.
- Visit **www.Humana.com** to view provider availability
  - Dental Network: PPO/Traditional Preferred
  - Vision Network: Humana Insight Network

Ready to Enroll? Please contact:
Kuhlmann Financial Services, Inc.
EnrollMSAPro@kuhlmannfin.com
Toll Free: 1-833-939-4002

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Extended annual maximum

Unique solution for extended coverage

Included only in the Premium (PPO) & Enhanced (TRP) Dental Plans

With Humana's **Extended annual maximum**, employees won't have to put off important dental care procedures for themselves or their covered dependents.

Extended annual maximum is available immediately after the annual maximum for a plan is reached, and there's no cap on the dollars paid in a year. That's an attractive advantage over traditional rollover options.

Extended annual maximum helps employees save money by ensuring they have access to network discounts and 30 percent coinsurance, even after they have reached their annual maximum. Employees can achieve and maintain their best health by getting dental care when it's needed, before oral health issues may affect their overall health and well-being.

Plus, the **Extended annual maximum** is a great way for groups and employees to buy down their annual maximum or coinsurance, or adjust plan deductibles and their out-of-network reimbursements.

30% coinsurance coverage after network discount and maximum benefit is reached

Uniquely different from traditional rollover plans:

- No need to delay care
- No paid claims thresholds
- No dollars to roll over
- No provider restrictions
- No mandatory claims submissions
- No need to track annual usage

Extended annual maximum advantages:

- **Simple** - all employees and their dependents have the same benefits
- **Easy** – the plan is easy to describe and administer
- **Immediate** – employees can use the benefit beginning day one
- **Available** – included in all Traditional Preferred (Plus) and PPO plan groups of two or more

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Humana Dental Option (PPO)
Dental PPO 14 - Premium Plan

MSA

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,500 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, molar teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	90% after deductible		80% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years for implant placement, crowns, bridges, and dentures) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years)	60% after deductible		50% after deductible	
Orthodontia services	Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.			

Humana Dental Option (TRP)
Traditional Preferred 14 - Enhanced Plan

MSA

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,000 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Composite fillings (1 per tooth every 2 years, molar teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	80% after deductible		80% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years for implant placement, crowns, bridges, and dentures) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years)	50% after deductible		50% after deductible	
Orthodontia services	Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.			

Humana Dental Option (Prev Plus) Preventive Plus 14 - Value Plan

MSA

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,000			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (routine extractions)	50% after deductible		50% after deductible	
More Value **Basic services** • Stainless steel crowns • Harmful habit appliances for children **Major services** • Crowns • Inlays and onlays • Bridges • Dentures • Denture relines/rebases • Denture repair and adjustments • Implants • Periodontics (gums) • Endodontics (root canals) **Orthodontia services** • Adult and child orthodontia	These services are not covered under this plan. Members may receive a discount on non-covered services and may contact their participating provider to determine if any discounts are available on non-covered services.			

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Humana Dental

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Voluntary funding:

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	Not available
Late applicant [1, 2]	No	12 months	12 months	Not available

[1] Late applicants not allowed with open enrollment option.
[2] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

Dental Exclusions and Limitations

Please refer to the master certificate for exclusions and limitations on these 3 dental plans.

Humana Vision 160 Premium Plan

MSA

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	$0	Up to $30
• Premium contact lens fit and follow-up	10% off retail less $55 allowance	Up to $30
Frames[3]	$160 allowance 20% off balance over $160	$80 allowance
Standard plastic lenses[4]		
• Single vision	$10	Up to $25
• Bifocal	$10	Up to $40
• Trifocal	$10	Up to $60
• Lenticular	$10	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	$10	Up to $25
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$22	Up to $25
- Tier 2	$33	Up to $25
- Tier 3	80% of charge less $35 allowance	Up to $25
• Standard progressive (add-on to bifocal)	$10	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$45	Up to $40
- Tier 2	$55	Up to $40
- Tier 3	$70	Up to $40
- Tier 4	$25 copay, 80% of charge less $120 allowance	Up to $40
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	80% of charge	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$160 allowance, 15% off balance over $160	$128 allowance
• Disposable	$160 allowance	$128 allowance
• Medically necessary	$0	$210 allowance

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Humana Vision 160

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 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

Riders Included

• 12-month Frame Benefit	Benefit replaces the 24-month frequency of the base plan.
• 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 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 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.

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Humana Vision 130 Enhanced Plan

MSA

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]	$130 allowance 20% off balance over $130	$65 allowance
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 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

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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		
• 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

Riders Included

• 12-month Frame Benefit	Benefit replaces the 24-month frequency of the base plan.
• 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 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 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.

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Vision 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].

Humana

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.

1 Thompson Media Inc.