Cost proposal prepared for:

State of Nebraska

RFP 6729 Z1

Quote Date: December 2, 2022

Effective Date: July 1, 2023

Submitted by:
Drew Aldridge | Sales Executive | 815-546-0288 | daldridge8@humana.com

COST PROPOSAL

Table of Contents

Humana Offering Company Statement

The benefits outlined in this proposal are offered by the following company, hereafter referred to as "Humana:"

- Fully insured Humana Vision plans in Nebraska are insured by Humana Insurance Company

Humana Inc. is the ultimate parent company and not an offering company. Humana Inc. holds no insurance licenses or health plan licenses.

Humana has provided information and responses that are consistent with current internal policies and procedures; however, clients will receive the newest and most innovative solutions that Humana has to offer at the time of implementation.

ATTACHMENT 1 - VISION INSURANCE PLAN COST PROPOSAL

REQUEST FOR PROPOSAL NUMBER 6729 Z1

Bidder Name: Humana

Bidders shall fill in the proposed monthly premium amounts for each column provided below. All premium amounts specified are guaranteed by Bidder and are inclusive of all costs. Each monthly premium amount proposed should be evenly divisible by "2" with no rounding to accommodate two even deductions per month through our payroll system. Any premium amount not divisible by "2" will be reduced to the nearest lower amount that is divisible by "2" for scoring. By submitting this proposal, Bidder accepts this lower amount if a contract is awarded.

The State is seeking proposals from qualified insurance vendors to provide a fully-insured Vision Insurance plan for their approximately 15,200 eligible State employees. The contribution is 100% by the employee.

Census information	Basic Plan	Premium Plan
Employee Only	1634	3365
Employee + Spouse	553	1549
Employee + Dependent Child(ren)	360	1072
Employee + Spouse + Dependent Child(ren)	556	1832
COBRA	16	60
Pre-65 Retirees	35	86

	Initial Period Years 1 - 3		First Renewal Period Year 4		Second Renewal Period Year 5		Third Renewal Period Year 6	
	Basic Plan	Premium Plan	Basic Plan	Premium Plan	Basic Plan	Premium Plan	Basic Plan	Premium Plan
Employee Only	$4.92	$7.64	$4.92	$7.64	$4.92	$7.64	$4.92	$7.64
Employee + Spouse	$7.90	$12.22	$7.90	$12.22	$7.90	$12.22	$7.90	$12.22
Employee + Dependent Child(ren)	$8.06	$12.44	$8.06	$12.44	$8.06	$12.44	$8.06	$12.44
Employee + Spouse + Dependent Child(ren)	$12.98	$20.10	$12.98	$20.10	$12.98	$20.10	$12.98	$20.10

All costs are inclusive. If costs are entered into the fields below, it is the bidders responsibility to include them in the proposed monthly premium amounts in the table above.

Guarantees & Credits	Initial Period Years 1 - 3	First Renewal Period Year 4	Second Renewal Period Year 5	Third Renewal Period Year 6
Guaranteed Rates (Y/N)	Y	Y	Y	Y
Enrollment Change Tolerance (+/- XX%)	15%	15%	15%	15%
Annual Communications Credit ($)	$15,000	$15,000	$15,000	$15,000

Humana®

Proposal for:

The State of Nebraska

Proposed coverage:

- Vision

Effective date:

07/01/2023

Humana sales representative:

Drew Aldridge

Reference number: 328330717

Proposal date: 11/30/2022

Fully Insured
Effective date: 07/01/2023

Vision Plan Highlights and Rates

Proposed plan 1: Custom Humana Vision 100 Plan

Plan Highlights			
Lens/Contact Lens Frequency (months)	24	Exam with Dilatation Copay Par	$10
Single Lens Allowance NonPar	$25	Exam Frequency (months)	12
Exam with Dilatation Allowance NonPar	$30	Polycarbonate Lens for Children Benefit	Yes
Frame Frequency (months)	24	Retinal Imaging Benefit	Not Selected
Contact Lens Allowance Par	$105	LASIK/PRK Benefit	Not Selected
Contact Lens Allowance NonPar	$80	Both Eyeglass and Contact Lens Benefit	Not Selected
Retail Frame Allowance Par	$105	12 Month Frame Benefit	Not Selected
Frame Allowance NonPar	$50	Voluntary Participation	Not Selected
Materials Copay Par	$10		

	EE	EESP	EECH	FAM
Assumed subscribers	1,685	553	360	556
Proposed rates	$4.92	$7.90	$8.06	$12.98
Estimated monthly premium	$8,290.20	$4,368.70	$2,901.60	$7,216.88
Estimated annual premium	$99,482.41	$52,424.40	$34,819.20	$86,602.56

Fully Insured
Effective date: 07/01/2023

Vision Plan Highlights and Rates

Proposed plan 2: Custom Humana Vision 130 Plan

Plan Highlights			
Lens/Contact Lens Frequency (months)	12	Exam with Dilatation Copay Par	$10
Single Lens Allowance NonPar	$25	Exam Frequency (months)	12
Exam with Dilatation Allowance NonPar	$30	Polycarbonate Lens for Children Benefit	Yes
Frame Frequency (months)	12	12 Month Frame Benefit	Yes
Contact Lens Allowance Par	$130	Retinal Imaging Benefit	Not Selected
Contact Lens Allowance NonPar	$104	LASIK/PRK Benefit	Not Selected
Retail Frame Allowance Par	$120	Both Eyeglass and Contact Lens Benefit	Not Selected
Frame Allowance NonPar	$65	Voluntary Participation	Not Selected
Materials Copay Par	$10		

	EE	EESP	EECH	FAM
Assumed subscribers	3,511	1,549	1,072	1,832
Proposed rates	$7.64	$12.22	$12.44	$20.10
Estimated monthly premium	$26,824.04	$18,928.78	$13,335.68	$36,823.20
Estimated annual premium	$321,888.47	$227,145.38	$160,028.16	$441,878.38

Limitations, exclusions, waiting periods, and frequency or age limitations may apply. Do not cancel current group coverage until you receive written approval from Humana. Please verify the rates and selected plan(s) before implementation to ensure a smooth transition.

Fully Insured

Vision Plan Terms and Conditions

Rate Assumptions:

- The effective date is no later than 07/01/2023.
- Rates are based on SIC code 9111, situs state NE.
- Plan assumes an employer/employee relationship exists between all parties.
- These rates include a replacement commission schedule of a level 0%.
- Humana requires any producer transacting the sale of insurance products on Humana's behalf to be contracted with Humana and appointed as Humana's agent in accordance with applicable law. The provision of this quoting information to the producer does not constitute an authorization of the named producer to solicit or otherwise transact the sale of insurance products on behalf of Humana, its affiliates, or subsidiaries. The information presented in this quote is intended for a producer's informational purposes only and shall not be distributed further.
- Rates assume no changes in legislation or regulation that affect benefits payable, eligibility, or contractual provisions.

Enrollment:

- Rates are based on 16780 eligible employees.

Plan Design:

- This plan is based on Humana's vision standard certificate language and includes custom benefits. To ensure quality, Humana requires a 21-day notice before the effective date to complete all facets of implementation and quality-assurance testing. Tasks during this time include internal and external meetings to discuss plan design, receiving and loading eligibility, building plan-specific benefits; and creating, printing and mailing ID cards.
- Dependent age limitations are based on situs state requirements unless otherwise noted.
- Proposal is contingent on Humana being the only vision plan offered.

Billing:

- With our standard billing cycle, premiums are due by the first of the month for which coverage is to be provided. Grace period is 31 days.
- Humana may adjust rates because of changes in plan design, legislation, or regulations that affect benefits payable, eligible, or contractual provisions.

Rate are guaranteed for six (6) years from 07/01/2023 through 06/30/2029.

This proposal provides for the reimbursement of costs often referred to as communication credits. Humana will reimburse the policyholder up to $15,000 annually through an Administrative Services Agreement which credits the policyholder#s second month#s billed premium. An executed Administrative Services Agreement is required.

For insuring or offering entity, please see applicable sales or marketing literature.

Humana Vision 100

The State of Nebraska

NEBRASKA

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 $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	Up to $105 20% off balance over $105	$50 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	$0	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)	$25	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	$105 allowance, 15% off balance over $105	$80 allowance
• Disposable	$105 allowance	$80 allowance
• Medically necessary	$0	$200 allowance

Humana Vision 100

NEBRASKA

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 24 months	Once every 24 months
• Frame	Once every 24 months	Once every 24 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
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 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.

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 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.

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®

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.

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. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

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.

Humana®

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'dęę́ nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0721

Humana Vision 130

The State of Nebraska

NEBRASKA

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 $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$120 allowance 20% off balance over $120	$65 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	$0	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

Humana Vision 130

NEBRASKA

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
Optional benefits		
• 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.

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?

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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®

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.

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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.

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