Cincinnati Public Schools

		If you use an IN-NETWORK provider (Member Cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Routine eye exam	Exam with dilation, as necessary	$10	Up to $30
	Retinal imaging[1]	Up to $39	Not covered
Contact lens[2] exam options	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*		Up to $150, 20% off balance over $150	Up to $65
Standard plastic lenses[3]	Single vision	$10	Up to $25
	Bifocal	$10	Up to $40
	Trifocal	$10	Up to $60
	Lenticular	$10	Up to $100
Lens options[3]	UV coating	$15	Not covered
	Tint (solid and gradient)	$15	Not covered
	Standard scratch-resistance	$15	Not covered
	Standard polycarbonate		
	• Adults	$40	Not covered
	• Children <19	$40	Not covered
	Standard anti-reflective coating	$45	Not covered
	Premium anti-reflective coating		
	• 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		
	• 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

* Discounts available on all frames except when prohibited by the manufacturer

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Contact lenses (Applies to materials only)	Conventional	Up to $150, 15% off balance over $530	Up to $104
	Disposable	Up to $150	Up to $104
	Medically necessary	$0	Up to $200
Frequency	Examination	Once every 12 months	Once every 12 months
	Lenses or contact lenses	Once every 12 months	Once every 12 months
	Frames	Once every 12 months	Once every 12 months
Diabetic Eye Care (Care and testing for diabetic members)	Exam	$0	Up to $77
	Retinal imaging	$0	Up to $50
	Extended ophthalmoscopy	$0	Up to $15
	Gonioscopy	$0	Up to $15
	Scanning laser	$0	Up to $33
	(Up to 2 services per benefit year for each listed service)		

ADDITIONAL PLAN DISCOUNTS

Member may receive a 20% discount on items not covered by the plan at network Providers. 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 specially trained providers, this discount may not always be available from a provider in your immediate location.

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 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

Limitations and Exclusions:

Plan limitations and exclusions may vary based on benefits selected. Please see your certificate of coverage for a complete listing of your limitations and exclusions.

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 vision examination, vision materials.

22 Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this policy.

23 Non-prescription sunglasses except for 20% discount

24 Two pair of glasses in lieu of bifocals

25 Services or materials provided by any other group benefit plans providing vision care.

26 Certain name brands when manufacturer imposes no discount.

27 Corrective vision treatment of an experimental nature

28 Solutions and/or cleaning products for glasses or contact lenses

29 Contact lenses

30 Pathological treatment

31 Non-prescription items

32 Costs associated with securing materials

33 Pre- and Post-operative services

34 Orthokeratology

35 Routine maintenance of materials

36 Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.

37 Artistically painted lenses

Vision products insured by Humana Insurance Company of Humana Insurance Company of Kentucky of Humana Health Benefit Plan of Louisiana, Inc.

This is not a complete disclosure of plan qualifications and limitations. Check with your local Humana sales office to verify product availability.

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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