**SECTION V: Response Forms**

**Exhibit II: Vision Plan Response Form – Please Complete Below Form**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Current** | **Proposed (Please Fill out the Chart Below)** |
| **SCHEDULE OF BENEFITS** | **Humana** |  |
|  |   | ***In Network*** | ***Non Network*** | ***In Network*** | ***Non Network*** |
| Exam Copay |  | $10 | Up to $30 |   |
| **Frequency** |   |  |  |  |  |
| Exam Copay |  | 12 months |   |
| Lenses |  | 12 months |   |
| Frames |  | 24 months |   |
| **Benefits Payable** |   | ***Copay*** | ***Reimbursement*** |  |  |
| Eye Exam |  | $10 | $30 |   |   |
| Single Lenses |  | $15 | $25 |   |   |
| Bifocal Lenses |  | $15 | $40 |   |   |
| Trifocal Lenses |  | $15 | $60 |   |   |
| Lenticular Lenses |  | $15 | $100 |   |   |
| **Lenses and Frames** |   | ***Reimbursement*** | ***Reimbursement*** |  |  |
| Contact Lenses (Conventional) | $130 + 15% discount above $130 | Up to $104 |   |   |
| Contact Lenses (Disposable) | $130 allowance | Up to $104 |  |  |
| Contact Lenses (Medically Necessary) | Paid in Full | Up to $200 |   |   |
| Frames |  | $130 + 20% discount above $130 | Up to $65 |   |   |
| **Rate Guarantee** |  | **Expires 12/31/2025** |  |
| Employee | 738 | $5.12  |   |
| Employee + One | 241 | $10.24  |   |
| Employee + Family | 168 | $13.69  |   |