**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 | | |  | |