LUMEN®

(Insight - Walmart Network)

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	**$0 copay**	$10 copay	Up to $40
Retinal Imaging	$0 copay	$0 copay	Up to $20
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-up – Standard	Up to $40; contact lens fit and two follow-up visits	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up – Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	**$0 copay; 20% off balance over $185 allowance**	$0 copay; 20% off balance over $160 allowance	Up to $112
STANDARD PLASTIC LENSES			
Single Vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70
Progressive – Standard	$25 copay	$25 copay	Up to $50
Progressive – Premium Tier 1 - 4	$110 - 200 copay	$110 - 200 copay	Up to $50
LENS OPTIONS			
Anti Reflective Coating – Standard	$45	$45	Up to $5
Anti Reflective Coating – Premium Tier 1 - 3	$57 - 85	$57 - 85	Up to $5
Photochromic – Non-Glass	$0 copay	$0 copay	Up to $5
Polycarbonate – Standard	$40	$40	Not covered
Polycarbonate – Standard < 19 years of age	$0 copay	$0 copay	Up to $5
Scratch Coating – Standard Plastic	$15	$15	Not covered
Tint – Solid and Gradient	$0 copay	$0 copy	Up to $5
UV Treatment	$15	$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES			
Contacts – Conventional	$0 copay; 15% off balance over $150 allowance	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts – Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts – Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $210
LOW VISION			
Supplemental Testing	Covered in full	Covered in full	Up to $125 allowance
Low Vision Aids	25% copay up to $1,000	25% copay up to $1,000	25% copay up to $1,000
OTHER			
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every calendar year	Once every calendar year
Frame	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Contact Lenses	Once every calendar year	Once every calendar year
Low Vision	Once every other calendar year	Once every other calendar year

(Plan allows member to receive either contacts and frame, or frames and lens services)

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Savings plus convenience plus choice

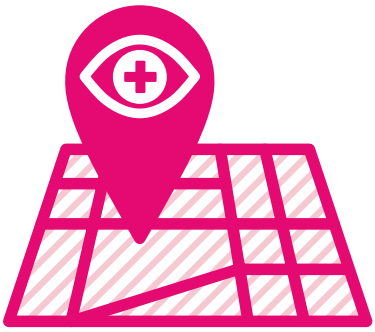
PLUS Providers add another layer of coverage

$185
Frame allowance

$0
Exam copay

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.



The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 855.874.4744. or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL