



## **REFRACTIVE SURGERY DISCOUNTS**

### **IN-NETWORK**

**15% discount** off the usual and customary surgical fees at US Laser Network.

### **OUT-OF-NETWORK - Not Covered**

**Covered Expenses will not include and no benefits will be payable for expenses incurred for:**

- lenses more than the frequency as indicated on the plan summary page.
- frames more than the frequency as indicated on the plan summary page.
- contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens benefit during the twelve month period. When eyeglass lenses are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
- contacts limited to the amount shown on the plan summary page unless they are medically necessary. Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:
  - keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
  - high Ametropia exceeding -12 D or +9 D in spherical equivalent.
  - anisometropia of 3 D or more.
- patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

If the member is diagnosed with a medically necessary condition, the Provider will submit a request for pre-authorization to EyeMed. The Medical Director reviews all requests for medically necessary contact lenses. If approved, the member will be covered for medically necessary contact lenses up to the plan allowance. Such payment is limited to once in any twelve month period and is in lieu of lens benefits under this proposal.

- orthoptics or eye care training and any associated testing.
- plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- two pairs of glasses in lieu of bifocals. (Does not apply to Secondary Discounts).
- lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- medical and/or surgical treatment of the eye, eyes, or supporting structures.
- services for which a claim is filed more than 1 year after completion of the service.
- for any procedure not listed on the Schedule of Eye Care Services.

**Monthly High Plan Rates**

Employee Only	\$9.08
Employee & Spouse	\$19.24
Employee & Child(ren)	\$16.48
Employee & Family	\$26.64

**Member Services, Provider Listings and Claims Services:  
866.939.3633**

**Fax for Claims:  
866.293.7373**

**Web Site:  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)**

**Address:  
EyeMed Vision Services, Inc  
4000 Luxottica Place  
Mason, OH 45040**

