



TENNESSEE VALLEY AUTHORITY

New Vision Plan Announcement

Effective **March 1, 2001**, TVA has chosen EyeMed Vision Care for all Preferred Provider Organization enrollees as the provider for quality eye care services. The network of EyeMed Vision Care providers consists of private practicing optometrists, ophthalmologists, opticians, plus the nation's leading optical retailer, LensCrafters, throughout the country. Our eye care professionals are looking forward to meeting your vision care needs, and are confident that you will find complete satisfaction in their services and products.

Receiving your vision benefit is as easy as visiting your EyeMed provider. A complete description of your vision care benefit is detailed below.

If you receive services from network providers, you pay only the copayments shown below, up to plan limits. If you receive vision care services from out-of-network providers, you must pay the full amount at the time of service. You would then apply for reimbursement and receive the amounts shown below as the Out-of-Network benefit. [See form below.](#)

If your eyecare provider is not a part of EyeMed's network, you may submit a nomination for that provider, and EyeMed will contact the provider to see if he or she is interested in becoming a part of the network. [See form below.](#)

Vision Care Services

	<i>In-Network Member Pays</i>	<i>Out-of-Network Member Is Reimbursed</i>
Exam with Dilation as Necessary:	\$10 Copay	Up to \$35
Standard Plastic Lenses:		
Single Vision	\$10 Copay	Up to \$25
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$55
Basic Progressives	\$10 Copay	Up to \$55
Lenticular	\$10 Copay	Up to \$55
Frames:	\$10 Copay; \$100 Allowance; 80% of retail over \$100.*	Up to \$45
Lens Options: (added to the base price of the lenses)		
UV Coating	\$12	
Tint (Solid and Gradient)	\$12	
Scratch-Resistant	\$12	
Basic Polycarbonate	\$35	
Standard Anti-Reflective	\$45	
Other Add-Ons and Services	20% off Usual & Customary charges	
Contact Lenses: (in lieu of a frame and lenses; includes fit, follow-up & materials)		
Conventional	\$10 copay; \$115 Allowance; 15% off balance over \$115	Up to \$98
Disposables	\$10 copay; \$115 Allowance; balance over \$115	Up to \$98
Medically Necessary	\$ 250 Allowance; balance over \$250	Up to \$200
LASIK and PRK Vision Correction Procedures	15 % off retail price**	

Frequency:

Examination	Once every 12 months
Frame	Once every 24 months
Lenses	Once every 12 months

Contact Lenses Once every 12 months

*Prescription sunglasses are covered following applicable co-payments up to plan allowances.

*Retail prices may vary by location.

*Member will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services or disposable contact lenses.

**LASIK and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.

Provider Recruitment Request Form

If there is a specific vision care provider you would like to see added to the EyeMed network, please fill in the information below. EyeMed would be happy to extend an application to the provider.

Provider Information:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Member Requesting The Provider:

Name: _____

Company: _____

Address: _____

Phone: _____

Fax: _____

May we use your name when we contact the requested provider? **YES** **NO**

Please note that all providers must meet EyeMed's standard terms and agreements to be included on the EyeMed network.

Thank you for your request.

**FAX THIS FORM TO:
EYEMED PROVIDER RELATIONS - 513-697-3024**

**Or Mail to:
EyeMed Provider Relations Dept.
8600 Governor's Hill Dr. Cincinnati, OH 45249
1-888-4EYEMED**





OUT OF NETWORK

Dear Member:

You have requested an Out of Network claim form for vision services to be provided outside of the EyeMed Vision Care network.

EyeMed plans allow members to select the provider of their choice, in or out of the network. EyeMed has designed benefit plans to deliver the quality care, matched with comprehensive benefits, at the most affordable cost, through our in-network services. Members also have the flexibility to visit an out-of-network provider, with a reduction in benefits.

If you choose to go to an Out of Network provider, please complete the following steps prior to submitting your Out of Network claim form.

1. Visit your provider of choice to receive vision care services. Please remember, you are responsible for payment of vision care services at the time of service. EyeMed Vision Care will reimburse you for authorized services according to your plan design. Please consult your plan design for the listing of qualified services and their reimbursement amounts.
2. Complete the Patient Information portion of your claim form.
3. Complete the Plan Information Portion of your claim form. This information can be found on your benefit card or by contacting your Human Resources Department.
4. Complete the Request for Reimbursement portion of the form.
5. If the patient is a minor, the parent or legal guardian should sign the claim form.
6. Attach itemized receipts from your provider to the claim form. Please include the following breakdown of costs:

EXAM
FRAMES

LENSES (specific prescription and type of lenses)
CONTACT LENSES (specific prescription and type of lenses)

7. Mail the claim form to:

EyeMed Vision Care Claims Processing
P.O. Box 429491
Cincinnati, OH 45242-9491

or fax all the information to (513) 697-3066.

If you would want to be pre-authorized for vision care benefits, please contact EyeMed toll-free at 1-866-439-3933, Mon. – Fri. 8 a.m. – 5 p.m. EST. After hours, please leave a voice mail request, including patient name, Member ID and the requested services and your daytime telephone number. This will ensure your eligibility for vision care benefits.

If you submit incomplete documentation, a delay in reimbursement may occur. Without prior authorization for services, there is a risk that you may not receive the entire benefit you are requesting reimbursement for.

Thank You,

EYEMED VISION CARE



OUT OF NETWORK CLAIM FORM

