THE EYE CARE NETWORK

Discount Vision Program Information

TO : ECN PARTICIPATING PROVIDERS

SUBJECT : DISCOUNT VISION PROGRAM

Several years ago, The Eye Care Network (ECN) started a separate panel of participating providers that offers a twenty (20%) percent discount from "usual and customary" charges for routine eye examinations, lenses, frames, extras such as tints and coatings, and contact lenses. Although the coverage is extensive, the Discount Vision Program does not include disposable contact lenses, eyewear repairs, and the medical or surgical treatment of the eyes. Additionally, it may not be applied to any other promotional offers.

There are now over 2,800 ECN providers who are participating in the Discount Vision Program, which covers over 3,600,000 participants. Some of these participants also have a regular vision plan through ECN. In this cases, the discount if further applied to all non-covered services, materials, and out-of-pocket expenses such as overages. For example, if a member has a $75.00 retail frame allowance through the fully-insured vision plan and chooses a frame retailing for $100.00, the discount is given to the difference between the allowance and the actual frame cost (overage). In this example, the discount is applied to the $25.00 difference resulting In an additional $5.00 savings to the member.

If you wish to participate in the Discount Vision Program, please complete the attached form and return at your earliest convenience. The signed and dated form will confirm your participation and your information in our website directory will be updated accordingly.

If you have any further questions about the Discount Vision Program or your participation in ECN, please contact a representative at 1.800.877.6372, or log on to www.ecndiscount.com.

Thank you for your consideration and continued support of The Eye Care Network.

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Discount Vision Program
Provider Agreement

☐ I wish to participate in The Eye Care Network Discount Vision Program.

As a participating provider of the program, I agree to provide ECN annually, or ninety (90) days in advance of any proposed changes, a published list of standard "in-office charges". I understand that any amount that is determined to be an overcharge must be refunded.

Printed Name : _____

Street Address : _____

City/State/Zip : _____

Telephone : _____

ECN Provider No. : _____

Signature : _____

Date : _____

Participating provider with multiple locations need to complete only one form. All locations will automatically be designated as Discount Vision Program locations upon receipt of the completed form.

Mail of fax completed form to:

THE EYE CARE NETWORK

345 Baker Street
Costa Mesa, CA 94104
Fax: 714.619.4662