VISION by Design

This is an outline of Vision Insurance Coverage underwritten by Companion Life Insurance Company.

D/S Services, Inc.

Group Number 902-14-38340

Vision SELECT	Exam and Eyewear	
	In-Network	Out-of-Network Allowance*
Vision Exam with Dilation (as necessary)	$10 Copay	$35 allowance
Contact Lens Fit and Follow-up: (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard**	$0 Copay	$40 allowance
Premium***	$55 allowance, 10% off balance over allowance	$40 allowance
Frequency	12 months†	12 months†
Standard Plastic Lenses		
Single	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Other Add-ons and Services	20% off retail	N/A
Frequency	12 months†	12 months†
Lens Options		
UV Coating	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Scratch Resistant Coating	$15 Copay	N/A
Standard Polycarbonate	$40 Copay	N/A
Standard Anti-Reflective Coating	$45 Copay	N/A
Standard Progressive (Add-on to Bifocal)	$75 Copay	$40
Premium Progressive (Add-on to Bifocal)	$75 Copay plus 80% of charges over $120 allowance	$40
Contact Lenses (Material Only)		
Conventional	$80 allowance, 15% off balance over allowance	up to $64
Disposable	$80 allowance	up to $64
Medically Necessary	Paid in full	$200
Frequency	12 months†	12 months†
Frames		
Any available frame at provider location. Benefit is not available on those frames where the manufacturer prohibits a discount.	$100 allowance, 20% off balance over allowance	up to $45
Frequency	24 months‡	24 months‡

Call 866-723-0596 to locate the nearest EyeMed provider, or visit EyeMedVisionCare.com.

*When services are obtained from an out-of-network provider, a claim form must be filed with EyeMed for reimbursement.

**Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

***Premium Contact Lens Fitting – all lens designs, materials and specialty fittings other than Standard (e.g., toric, multifocal, etc.)

†Once in a 12-month period defined by last date of service.

‡Once in a 24-month period defined by last date of service.

The contact lens benefit is paid in lieu of eyeglass lenses. Eyeglass lenses are paid in lieu of the contact lenses benefit.

These benefits are provided by Policy Form No. CL-VIS-2000-P-MI.

Companion Life

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Vision Insurance Limitations and Exclusions

Limitations

Oversized Lenses are not a covered benefit. An Insured Individual requesting these lenses will be required to pay the difference in charges.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, sub-normal vision aids, and any associated supplemental testing;
2. aniseikonia lenses;
3. medical and/or surgical treatment of the eye, eyes or supporting structure;
4. corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan;
5. services provided as a result of any Workers' Compensation law;
6. plain non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. services or materials provided by any other group benefit providing for vision care;
8. two pair of glasses in lieu of bifocals.

Companion Life

P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 | 800-836-5433 fax
CompanionLife.com

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