

VISION by Design

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

Rates Effective: 01/01/22

Grey Havens LLC Group Number 785-14-06270

Defined Contribution Insurance Plan

Vision SELECT	Exam and Eyewear	
	In-Network	Out-of-Network Allowance*
Vision Exam with Dilatation (as necessary)	\$20 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***	\$0 Copay	\$40 allowance
Frequency	12 months†	12 months‡
Standard Plastic Lenses		
Single	\$20 Copay	\$25
Bifocal	\$20 Copay	\$40
Trifocal	\$20 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)	\$45 Copay	N/A
Premium Progressive (Add-on to Bifocal)	\$85 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		
<i>Any available frame at provider location. Benefit is not available on those frames where the manufacturer prohibits a discount.</i>	\$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-OH.



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Monthly Rates (12 pay periods)

Rates are guaranteed for 12 months.

Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
\$ 7.53	\$ 14.20	\$ 16.80	\$ 22.36

Vision Insurance Limitations and Exclusions

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

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
4. Corrective 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. Plano non-prescription lenses and non-prescription sunglasses (except 20% discount);
7. Services or materials provided by any other group benefit providing for vision care; or
8. Two pair of glasses in lieu of bifocals.

This Benefits Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.



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

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