

## Coverage you can actually see



Vision

The Chesapeake Life Insurance Company® offers a vision plan that complements your health insurance plan and delivers savings on both eye examinations and eyewear.

Through EyeMed Vision Care's Select Network, our vision plan offers thousands of retail providers nationwide, including locations in large retail stores such as Target,® Sears,® LensCrafters,® Pearle Vision® and other private practitioners.

### To locate a provider, follow these simple steps:

- 1) Call Eyemed Vision Care direct at 1-866-723-0514 (Mon.-Sat., 8AM-11PM; Sun., 11AM-8PM)
- 2) Log on to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)
  - Locate a provider
  - In the drop box, choose the "Select" network
  - Enter your zip code, then you will see a listing of providers near you

**Contact your local agent**  
to learn more about how you can  
customize or combine multiple plans to fit  
your specific budget and needs.

The plan is not available in the following zip codes: 01230, 01238, 01245, 01253, 01255, 01257, 01258, 01260, 01262, 01263, 01264, 01266, 02554, 02564, and 02584

<sup>1</sup> EyeMed is a discount program only and not insurance. This program provides discounts only at certain contracted providers. You are obligated to pay all health care fees at the time of service, but will receive a discount from those providers who have contracted with the discount plan organization. The program does not make payments directly to the providers of medical services. *EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040, and has no liability for providing or guaranteeing service or the quality of service.*

This supplemental insurance product is underwritten and administered by The Chesapeake Life Insurance Company. The administrative offices of The Chesapeake Life Insurance Company are located in North Richland Hills, TX. Insurance product availability may vary by state. For premium costs and further details of form series CH-26023-IP (05/07) MA, including exclusions, any reductions or limitations and the terms under which the Policy may be continued in force, please contact your licensed insurance agent/producer. A Disclosure Statement of Consumer Protections is available upon request.  
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CH/MA000006 Exp. 7/12

### Vision

#### Eye Exam

Covered at 100%

#### Lenses

Standard uncoated plastic lenses are covered at 100%

#### Contact Lenses

Non-Disposable: 100% up to \$40. 15% off balance over \$40  
 Disposable: 100% up to \$40  
 Therapeutic: 100%

#### Additional Savings from EyeMed<sup>1</sup>

Frames: 60% of retail  
 Standard Polycarbonate: \$40  
 Standard Scratch-Resistance: \$15  
 Tints (Solid and Gradient): \$15  
 Standard Progressive Lenses: \$65  
 Premium Progressive Lenses: \$65+ (80% of retail) less \$120 allowance  
 UV Coating: \$15  
 Standard Anti-Reflective: \$45  
 Nonprescription glasses and sunglasses: 80% of retail  
 Other Lens Options: 80% of retail  
 LASIK or PRK Vision Correction: 15% off retail or 5% off promotional price

# THE CHESAPEAKE LIFE INSURANCE COMPANY®

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-815-8535

## VISION INSURANCE POLICY

### OUTLINE OF COVERAGE for Form: CH-26023-IP (5/07) MA

#### This plan does not contain a Pre-Existing Condition Provision

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. 10 DAY RIGHT TO EXAMINE THE POLICY** -It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our Administrative Office in North Richland Hills, Texas within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, and You will receive a full refund of all the premiums You have paid.
- 3.** Vision Benefit Coverage is designed to provide You or Your Covered Dependents with coverage paying benefits only when certain losses are incurred for vision services and supplies. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS AND LIMITATIONS section.
- 4. BENEFITS PROVIDED.** While the Policy is in force, benefits are provided for the Vision Care services and supplies shown in the Policy Schedule. Charges must be incurred for a Comprehensive Eye Examination, Corrective Spectacle Lenses and/or Corrective Contact Lenses as provided for by an authorized provider (i.e., ophthalmologist, optometrist, or optical dispensary). Payment of benefits for any such service or supply will be made in accordance with the specified Benefit Payment Rate. The Benefit Payment Rate is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service.

#### **BENEFITS**

#### **NETWORK PROVIDER**

#### **NON-NETWORK PROVIDER**

#### **Comprehensive Eye Examination**

100%

80%

(Limited to one Comprehensive Eye Examination every 12 months from last date of service, per Insured Person.)

#### **Corrective Spectacle Lenses (standard, uncoated plastic lenses)**

(Limited to one purchase every 12 months from last date of service, per Insured Person.)

Single Vision Lenses

100%

80%

Bifocal Lenses

100%

80%

Trifocal Lenses

100%

80%

#### **Corrective Contact Lenses**

(In lieu of corrective spectacle lenses; limited to one purchase every 12 months from last date of service, per Insured Person.)

Non-disposable

100% up to \$40.00

100% up to \$32.00

Disposable

100% up to \$40.00

100% up to \$32.00

Therapeutic

100%

100%

- 5. LIMITATIONS AND EXCLUSIONS.** Certain expenses that You or Your Covered Dependents may incur for vision care do not qualify as Covered Expenses under the Policy.

### **EXCLUSIONS**

The Policy does not cover the following:

1. orthoptic or vision training and any associated supplemental testing;
2. plano lenses;
3. lens coating;
4. two pair of glasses, in lieu of bifocals or trifocals;
5. medical or surgical treatment of the eyes;
6. any type of corrective vision surgery, including LASIK surgery;
7. any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. any services or supplies when paid under any Worker's Compensation or similar law;
9. no-line bifocal or progressive lenses;
10. photochromic, transition, or polycarbonate lenses;
11. lenticular lenses;
12. sub-normal vision aids or non-prescription lenses;
13. services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. eyeglasses when the change in prescription is less than .5 Diopter;
15. experimental or investigational or non-conventional treatment or device;
16. eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, or edge polishing;
17. oversized lenses;
18. high index lenses of any material type;
19. fitting for contact lenses;
20. follow-up visits;
21. frames for corrective spectacle lenses; or
22. charges incurred after the Policy has terminated or coverage has ended.

### **LIMITATIONS**

Covered Expenses for services and supplies will be limited to once every 12 months from the last date of service.

- 6. RENEWAL CONDITIONS.** The Policy is conditionally renewable to age 75 or eligibility for Medicare, whichever occurs first, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

### **7. TERMINATION OF COVERAGE –**

#### **You**

Your coverage will terminate and no benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state;
7. On the date an Insured Person is no longer a permanent resident of the United States; or
8. On the date You reach the age of 75, or become eligible for Medicare, whichever comes first.

## Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the Limiting Age, and thereafter We may require such proof not more frequently than annually. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

8. **PREMIUMS.** Premiums are payable to the Company at its Administrative office. The Company reserves the right to change the table of premiums on a class basis, becoming due under the Policy at any time provided 31 days advance written notice is given.

Premium Due (at time of application) \$ \_\_\_\_\_

9. **COMPLAINTS:** If You have a complaint, call us at 1-800-889-8223 or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance.

**The Chesapeake Life Insurance Company®**

**Administrative Office:**

**P.O. Box 982010**

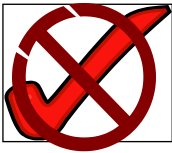
**North Richland Hills, TX 76182-8010**

**Toll Free: 1-800-815-8535**

This attachment page form CH-26023-IP (5/07) SS MA 7/11, must be used with the Vision Outline of Coverage when marketing. For details about covered expenses, exclusions and limitations of the Vision plan (form CH-26023-IP (5/07) MA), refer to the Outline of Coverage to which this is attached.

**Coverage Begins**

We require evidence of insurability before coverage is provided. Once we have approved your application based upon the information you provided, the effective date of coverage for you and those eligible dependents listed in the application and accepted by us will be the Policy Date shown in the Policy Schedule.



This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that You have health insurance.