Premiere Vision

Coverage to help keep your vision healthy and your world in focus

DID YOU KNOW?

3 in 4 Americans need some type of corrective lens.[1]

An annual eye exam is about much more than healthy vision. It can help identify the early signs of serious health conditions like diabetes and high blood pressure.

Our **Premiere Vision** plan offers access to **thousands of network providers nationwide** through EyeMed Vision Care's "Select" Network of independent providers and **retail chains** including: **LensCrafters®, Sears Optical®, Target Optical®, JCPenney Optical®** and **Pearle Vision®** locations.

Applying is simple and can be completed in minutes.

Premiere Vision Plan At A Glance

- 100% coverage for routine eye exam[2]
- Discounts on contact lenses and additional savings from EyeMed[3]
- Complements your Original Medicare insurance plan
- Large network of providers to choose from. For a list of participating providers, visit **EyeMedVisionCare.com** and choose the "Select" network
- Coverage is available for you and your spouse
- Affordable premiums that do not increase as you get older with individual coverage **for $10[20] per month**

Get coverage for your vision care needs. Apply today!

[1] www.StatisticBrain.com/corrective-lenses-statistics | [2] Per insured, per 12 month period. | [3] EyeMed is a discount program only and not insurance.

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Covering Life's Twists and Turns

Underwritten by *The Chesapeake Life Insurance Company®*

Premiere Vision

	Network Provider	Non-Network Provider
Eye Exam[1]	100% up to $30 (Member responsible for an additional $10 out-of-pocket amount)	100% up to $30 (Member responsible for any amount over $30)
Corrective Spectacle Lenses[1] (in lieu of corrective contact lenses)	Standard uncoated plastic lenses, with $10 copay • **Single Vision:** 100% up to $35 • **Bifocal:** 100% up to $55 • **Trifocal:** 100% up to $90	Standard uncoated plastic lenses, with $10 copay • **Single Vision:** 100% up to $35 • **Bifocal:** 100% up to $55 • **Trifocal:** 100% up to $90
Frames[1] (in lieu of corrective contact lenses)	$10 copay with $120 allowance	$10 copay with $84 allowance
Corrective Contact Lenses[1] (in lieu of corrective spectacle lenses and frames)	$10 copay with $120 allowance	$10 copay with $120 allowance
ADDITIONAL SAVINGS FROM EYEMED[2]		
You pay:		
Frames	60% of retail	
Lenses	• Standard Scratch Resistance: $15 • Standard Progressive Lenses: $65 • Standard Polycarbonate: $40 • Tints (Solid and Gradient): $15 • UV Coating: $15 • Premium Progressive Lenses: $65+ (80% of retail) less $120 allowance • 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	
MONTHLY PREMIUMS		
Individual	$10	
Two Persons	$18	

The chart above is only an illustration of benefit and premium options per insured per 12 month period.

[1] Per insured, per 12 month period | [2] EyeMed is a discount program only and not insurance. This program provides discounts only at certain contracted providers. You are obligated to pay all 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.

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OTHER IMPORTANT INFORMATION

Exclusions and Limitations from EyeMed:

Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing | Aniseikonic lenses | Medical and/or surgical treatment of the eye, eyes or supporting structures | Corrective eye wear required by an employer as a condition of employment, and safety eye wear unless specifically covered under plan | Services provided as a result of any Workers' Compensation Law | Plano nonprescription lenses and non-prescription sunglasses (except for 20% discount) | Services or materials provided by any other group benefit providing for vision care | Two pair of glasses in lieu of bifocals or trifocals

For a complete listing of benefits, exclusions and limitations, please refer to your Policy. In the event of any discrepancies contained in this brochure, the terms and conditions contained in the Policy documents shall govern. Vision Insurance Preferred Provider Organization (PPO) Policy. Form CH-26120-IP (01/12) OON GA.

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
PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM: CH-26120-IP (01/12) OON GA

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to health Insurance for People With Medicare available from the Company.

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. **VISION INSURANCE POLICY –** The Policy is designed to provide You or Your Covered Dependents with coverage 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 & LIMITATIONS section.

3. **BENEFITS –** While the Policy is in force, Covered Expenses include the fees associated with the Vision Care services and supplies shown below when provided 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 and any Deductible and Copayment Amounts shown below. The Benefit Payment Rate is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service. Any Deductible Amounts and/or Copayments will be applied first and then the Benefit Payment Rate will be applied.

Deductible (per Insured Person, per calendar year): $0

BENEFITS	**BENEFIT PAYMENT RATE**	
	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Comprehensive Eye Examination *(Limited to one Comprehensive Eye Examination every 12 months from last date of service, per Insured Person.)*	100% up to $30	100% up to $30
Corrective Spectacle Lenses (standard, uncoated plastic lenses) *(In lieu of corrective contact lenses; limited to one purchase every 12 months from last date of service, per Insured Person.)*		
Copayment (per Insured Person):	$10	
Single Vision Lenses	100% up to $35	100% up to $35
Bifocal Lenses	100% up to $55	100% up to $55
Trifocal Lenses	100% up to $90	100% up to $90

BENEFITS	BENEFIT PAYMENT RATE	
	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Frames	100% up to $120	100% up to $84

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

Copayment (per Insured Person): $10

Corrective Contact Lenses
(In lieu of Corrective Spectacle Lenses and Frames; limited to one purchase every 12 months from last date of service, per Insured Person.)

Copayment (per Insured Person): $10

Non-disposable	100% up to $120	100% up to $120
Disposable	100% up to $120	100% up to $120
Therapeutic	100% up to $120	100% up to $120
Contact Lens Fitting	Not Covered	Not Covered
Follow-Up Visits	Not Covered	Not Covered

4. **EXCLUSIONS & LIMITATIONS –** Benefits will not be provided under the Policy for expenses associated with 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. Photo-chromic, 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; or
   21. Charges incurred after the Policy has terminated or coverage has ended.

5. **RENEWABILITY** – The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. Any change in rates will be effective on the next following premium due date. Please read the Premium Changes provision of this Policy carefully. The Company reserves the right to change the applicable table of premium rates on a Class Basis with a 60 day written notice.

6. **BEGINNING OF COVERAGE -** We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, 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.

7. TERMINATION OF COVERAGE –

You

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

1. At the end of the period for which premium has been paid, subject to the Grace Period;
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 written request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your written request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. If the Insured Person performs an act or practice, that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of this Policy;
5. On the date We elect to discontinue this plan or type of coverage We will give You at least 90 written days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state We will give You and the Commissioner at least 180 days written notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

Covered Dependents

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

1. The date Your coverage terminates, except as provided under the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date the Covered Dependent performs an act or practice, which constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of this Policy; or
4. The date We receive Your written request to terminate a Covered Dependent's coverage.

Any unearned premium which has been paid by You will be refunded on a pro rata basis. Your cancellation shall be without prejudice to any claim originating prior to the effective date of Your cancellation.

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 after a two year period following the child's attainment of the Limiting Age. In the absence of such proof, We may terminate the coverage of such person after the attainment of the Limiting Age within 31 days.

8. PREMIUMS – We also reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any Policy anniversary; provided, We have given the Insured Person written notice of at least 60 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) $ _____

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For more information on SureBridge's supplemental insurance products, please visit

www.SureBridgeInsurance.com

SureBridgeInsurance.com

800-815-8535

Weekdays, 8am to 5pm in all time zones