Vision Coverage

Premiere Vision

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

Coverage For Your Vision Care Needs.

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®** and **most Pearle Vision®** locations.

Applying is simple and can be completed in minutes.

Premiere Vision At A Glance

100% coverage for routine eye exam[1]

Discounts on contact lenses and additional savings from EyeMed[2]

Large network of providers to choose from. For a list of participating providers, visit **eyemedvisioncare.com** and choose the "Select" vision network

Coverage is available for the whole family - you, your spouse and your kids

Affordable premiums that do not increase as you get older with individual coverage for **$10.00 per month**

Did You Know?

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

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

INSURED VISION PLAN[1]	Network Provider	Non-Network Provider
Eye Exam	100%, no copay	80%, no copay
Corrective Spectacle Lenses (in lieu of corrective contact lenses)	Standard uncoated plastic lenses, with $10 copay • 100%	Standard uncoated plastic lenses, with $10 copay • 80%
Frames[2] (in lieu of corrective contact lenses)	$10 copay 100% up to $120	$10 copay up to 80%
Corrective Contact Lenses[2,3] (in lieu of corrective spectacle lenses and frames)	$10 copay 100% up to $120	$10 copay up to 80%

For a list of participating providers, visit EyeMedVisionCare.com and choose the "Select" network | [1] Per insured, per 12 month period | [2] Benefits provided by non-network provider are based on non-network provider's fee and not a percentage of the amount paid to the provider network | [3] Limited to one year supply of contact lenses purchased every 12 months from last date of service, per insured person

ADDITIONAL SAVINGS FROM EYEMED VISION CARE[1]

In addition to your insured vision plan benefits, you have access to the following discounts through EyeMed where you pay:

Frames	20% off balance over $120 allowance
Contact Lenses, Non-Disposable	15% off balance over $120 allowance
Additional Pairs Benefit	Members also receive a 40% discount off a complete pair of eyeglasses and a 15% discount off conventional contact lenses once the funded benefits have been used
Lens Options	• Standard Polycarbonate: $40 • PRS Scratch Coat: $15 • Tints (Solid and Gradient): $15 • Standard UV Coating: $15 • Standard Anti-Reflective: $45 • Other Lens Options: 20% off retail
Non-Scheduled Items	20% off retail
LASIK or PRK Vision Correction	15% off retail or 5% off promotional price

MONTHLY PREMIUMS

Individual	$10.00
2 Persons	$17.50
Family	$27.50

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

[1] 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 EyeMed. The program does not make payments directly to the providers of services. This plan is not available in Dukes, Franklin or Nantucket counties.

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 non-prescription 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 MA.

Notice to Our Customers About Supplemental Insurance

- The supplemental plan discussed in this document is separate from any health insurance coverage you may have purchased with another insurance company.
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional protection.
- This plan is not required in order to purchase health insurance with another insurance company.
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

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 MA

EyeMed Vision Care has been selected as the network of participating eye care providers. The EyeMed network selected for this product is the Select network. Please note that not every EyeMed provider participates with all EyeMed networks. Please be sure to review your directory, login/register in the EyeMed website, www.eyemedvisioncare.com, with your username/login ID and password or call EyeMed Vision Care Customer Service at 1-866-723-0514 for information about a provider near you.

This plan is not available in Dukes, Franklin, and Nantucket County. Applicants residing in these counties seeking in-network levels of care must obtain services by a network provider within the approved service area.

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. **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, refund all premiums paid and treat the Policy as if it were never issued.

3. **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.

4. **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%	80%
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%	80%
Bifocal Lenses	100%	80%
Trifocal Lenses	100%	80%

BENEFITS	BENEFIT PAYMENT RATE	
	NETWORK PROVIDER	NON-NETWORK PROVIDER
Frames	100% up to $120	80%

(Benefits provided by Non-Network Provider are based on Non-Network Provider's fee and not a percentage of the amount paid to Network Provider)
(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

(Benefits provided by Non-Network Provider are based on Non-Network Provider's fee and not a percentage of the amount paid to Network Provider)
(In lieu of Corrective Spectacle Lenses and Frames; limited to one one year supply of contact lenses purchased every 12 months from last date of service, per Insured Person.)

Copayment (per Insured Person): $10

Non-disposable	100% up to $120	80%
Disposable	100% up to $120	80%
Therapeutic	100% up to $120	80%
Contact Lens Fitting	Not Covered	Not Covered
Follow-Up Visits	Not Covered	Not Covered

5. **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.

6. RENEWABILITY – The Policy is conditionally renewable, 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. 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.

8. 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; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

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; 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.

9. **PREMIUMS** – We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

10. **COMPLAINTS:** If You have a complaint, call us at 1-800-815-8535 or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance.

Premium Due (at time of application) $ _____

CH-26120-IP OC (01/12) OON MA

(800) 815-8535

Weekdays 8:00 a.m. to 5:00 p.m.
in all time zones