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 **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.

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**
- Coverage is available for you and your spouse
- Affordable premiums that do not increase as you get older with individual coverage **for $3^{50} 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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surebridge®
Covering Life's Twists and Turns

Underwritten by *The Chesapeake Life Insurance Company®*

Premiere Vision

VISION- Network Provider[1]	
Eye Exam[2]	Covered at 100%
Lenses[2]	Covered at 100% for standard, uncoated plastic lenses
Contact Lenses[2] (in lieu of corrective spectacle lenses)	• Non-Disposable: 100% • Disposable: 100%
ADDITIONAL SAVINGS FROM EYEMED[3]	
You pay:	
Frames	60% of retail
Lenses	• 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
MONTHLY PREMIUMS	
Individual	$3.50
Two Persons	$8.00

Make sure you are protected with other popular SureBridge products:

- Dental
- Final Expense Whole Life

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

[1] Non-network eye exams are covered 100% of the Network Provider negotiated rate, per 12 month period; other non-network services are not covered unless otherwise stated. See plan for details | [2] Per insured, per 12 month period | [3] 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.

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VISION: OTHER IMPORTANT INFORMATION

Coverage Information:

- **COVERAGE BEGINS:** Chesapeake requires evidence of insurability before coverage is provided. Once Chesapeake has approved your application and you have paid your premium, coverage will begin on the Policy date shown in the Policy schedule.

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 policy. Form CH-26023-IP (05/07) NH (01/12).

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.

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
www.Chesapeakeplus.com

VISION INSURANCE POLICY
OUTLINE OF COVERAGE for Form: CH-26023-IP (5/07) NH (01/12)

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 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.
3. **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.

   Covered Expenses include the following:

BENEFITS	**BENEFIT PAYMENT RATE**	
	Network Provider	**Non- Network Provider**
Comprehensive Eye Examination	100%	100% of the Network Provider negotiated rate
(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%	Not Covered
Bifocal Lenses	100%	Not Covered
Trifocal Lenses	100%	Not Covered
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%	Not Covered
Disposable	100%	Not Covered
Therapeutic	Not Covered	Not Covered
Frames	Not Covered	Not Covered
Contact Lens Fitting	Not Covered	Not Covered
Follow-Up Visits	Not Covered	Not Covered

4. **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. 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;
22. Therapeutic Contact Lenses; or
23. charges incurred after this 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.

5. **RENEWAL CONDITIONS.** 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. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

6. **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 (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 request of termination;
3. At the end of the month following the date of Our receipt of Your request of termination;
4. On the date of fraud or misrepresentation by You, subject to the Incontestability provision in the General Provision section;
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.

We will promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis.

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.

We will promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis.

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 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.

7. PREMIUMS. Premiums are payable to the Company at our administrative office in North Richland Hills, Texas. The Company reserves the right to change the table of premiums on a class basis, becoming due under the Policy at any time provided 60 days advance written notice is given. Premium rates will be guaranteed for twelve (12) months.

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

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