

SERFF Tracking Number: CSLI-126151728 State: Arkansas
 Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42386
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Group Vision - Associations & Labor Unions
 Project Name/Number: Group Vision - ASSC & LBUN/

Filing at a Glance

Company: Citizens Security Life Insurance Company

Product Name: Group Vision - Associations & Labor Unions SERFF Tr Num: CSLI-126151728 State: ArkansasLH

Labor Unions

TOI: H20G Group Health - Vision

SERFF Status: Closed

State Tr Num: 42386

Sub-TOI: H20G.000 Health - Vision

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Rickie Bolduc

Disposition Date: 05/28/2009

Date Submitted: 05/14/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Vision - ASSC & LBUN

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Association, Other

Filing Status Changed: 05/28/2009

Explanation for Other Group Market Type:

LABOR UNIONS

State Status Changed: 05/28/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed please find our group vision product for your review and approval. These are new policy forms and will not replace any existing forms.

Our group products are marketed by brokers and independent agents. This vision product will be a companion product to our group life and group dental products which are being filed concurrently with this filling, but under a separate

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SERFF number.

These forms will be marketed to Associations and Labor Unions on a voluntary basis.

The applications that will be used with this vision product are form # ASLU APP GLA 01 09 AR and form # ASLU ENR GLA 01 09 AR, which are being filed with the group life product.

A Statement of Variability is attached to the Master Policy and Certificate.

Company and Contact

Filing Contact Information

Rickie Bolduc, Actarial Associate rbolduc@cslico.com
 PO Box 436149 (502) 244-2431 [Phone]
 Louisville, KY 40253-6149 (502) 244-2439[FAX]

Filing Company Information

Citizens Security Life Insurance Company CoCode: 61921 State of Domicile: Kentucky
 12910 Shelbyville Road, Suite 300 Group Code: 1310 Company Type: Life and Accident
 and Health

PO Box 436149
 Louisville, KY 40253-6149 Group Name: Citizens Financial State ID Number:
 Group
 (502) 244-2420 ext. [Phone] FEIN Number: 61-0648389

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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CHECK NUMBER	CHECK AMOUNT	CHECK DATE
026179	\$50.00	05/13/2009

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/28/2009	05/28/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/19/2009	05/19/2009	Rickie Bolduc	05/20/2009	05/20/2009

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Disposition

Disposition Date: 05/28/2009

Implementation Date:

Status: Approved-Closed

Comment: The filing is being approved with the understanding that any association that this product is marketed through as the association being the policyholder, must have our Department's prior approval. Attached is a list of questions that needs to be submitted on each association.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document (revised)	COVER LETTER	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	COVER LETTER	Withdrawn	Yes
Supporting Document	ACTUARIAL MEMO	Approved-Closed	Yes
Supporting Document	STATEMENTS OF VARIABILITY	Approved-Closed	Yes
Form (revised)	GROUP VISION MASTER POLICY	Approved-Closed	Yes
Form	GROUP VISION MASTER POLICY	Replaced	Yes
Form (revised)	GROUP VISION CERTIFICATE	Approved-Closed	Yes
Form	GROUP VISION CERTIFICATE	Replaced	Yes

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
2. Is this group incorporated? If so, give state of incorporation.
3. Is there a current office in Arkansas?
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
5. Are annual dues charged? If so, specify amount.
6. What are the specific activities of the organization?
7. What benefits are provided to the members in addition to insurance?
PLEASE ATTACH BROCHURES ON THE BENEFITS.
8. What qualifies an individual for membership?
9. How are members recruited? If by mailing list, advise the source of this list.
10. Attach a copy of the organization by-laws.
11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
12. Please attach a copy of the organization's most recent financial statement.
13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/19/2009

Submitted Date 05/19/2009

Respond By Date

Dear Rickie Bolduc,

This will acknowledge receipt of the captioned filing.

Objection 1

- GROUP VISION CERTIFICATE (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity and the premium must remain at the child rate. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 05/20/2009

Submitted Date 05/20/2009

Dear Rosalind Minor,

Comments:

Please review the attached "2 Cover Letter" for details of the changes made.

Thank you for your help with this filing.

Response 1

Comments: See attached 2 Cover Letter for changes made.

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Related Objection 1

Applies To:
 - GROUP VISION CERTIFICATE (Form)
 Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity and the premium must remain at the child rate. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: COVER LETTER
 Comment: 2 Cover Letter details changes made.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
GROUP VISION MASTER POLICY	ASLU MAST GPA 02 09 AR		Policy/Contract/Fraternal Certificate	Revised		52	2 Form ASLU MAST GPA 02 09.pdf
Previous Version							
GROUP VISION MASTER POLICY	ASLU MAST GPA 02 09 AR		Policy/Contract/Fraternal Certificate	Initial		52	Form ASLU MAST GPA 02 09.pdf
GROUP VISION CERTIFICATE	ASLU CERT GPA 02 09 AR		Certificate	Revised		51	2 Form ASLU CERT GPA 02 09.pdf

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Previous Version

GROUP VISION	ASLU	Certificate	Initial	51	Form
CERTIFICATE	CERT				ASLU
	GPA 02				CERT
	09 AR				GPA 02
					09.pdf

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No Rate/Rule Schedule items changed.

Sincerely,
Rickie Bolduc

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Form Schedule

Lead Form Number: ASLU MAST GPA 02 09 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ASLU MAST GPA 02 09 AR	Policy/Contract/Fraternal Certificate	GROUP VISION MASTER POLICY	Revised	Replaced Form #: Previous Filing #: same	52	2 Form ASLU MAST GPA 02 09.pdf
Approved-Closed	ASLU CERT GPA 02 09 AR	Certificate	GROUP VISION CERTIFICATE	Revised	Replaced Form #: Previous Filing #: same	51	2 Form ASLU CERT GPA 02 09.pdf

CITIZENS VISION BENEFIT PLAN

UNDERWRITTEN and ISSUED BY
CITIZENS SECURITY LIFE INSURANCE COMPANY
12910 SHELBYVILLE ROAD, SUITE 300, LOUISVILLE, KY 40243
1-800-843-7752

ADMINISTERED and CLAIMS PAID BY

DAVIS VISION PLAN

159 Express Street
Plainview, NY 11803
1-800-999-5431

POLICYHOLDER: [Group Name]
POLICY NUMBER: [Group Number]
POLICY EFFECTIVE DATE: [January 1, 2007]
POLICY ANNIVERSARY: [January 1st]
POLICY ANNIVERSARY DATE: [January 1, 2008]
PREMIUM DUE DATE: [1st to the 15th of each month]
INITIAL TERM: [12 to 36 months]
POLICY DELIVERED IN: Arkansas and governed by the laws of that State

Citizens Security Life Insurance Company agrees to pay the benefits provided under this Group Policy through its Administrator, Davis Vision Plan, upon satisfactory written proof of loss with respect to each insured Member or each insured Dependent of a Member in accordance with the provisions of this Group Policy. The consideration for this Group Policy is the application of the Policyholder and the payment of the required premiums as they become due.

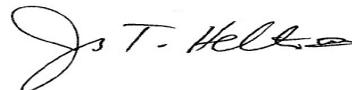
All periods indicated in this Group Policy begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

All provisions on this and the following pages are a part of this Group Policy. A Certificate of Insurance will be made available to the Insured Member and is part of the Group Policy. The definitions of terms in the Certificate of Insurance apply whenever the terms are used anywhere in this Group Policy. The terms "we", "us", "our" and "Company" refer to Citizens Security Life Insurance Company. The Policyholder may add new Members or Dependents from time to time in accordance with the terms of this Group Policy.

Signed on Behalf of Citizens Security Life Insurance Company:



John Cornett
President & COO



James T. Helton, III
Executive Vice President-Group

Group Insurance Policy

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SECTION ONE - POLICYHOLDER PROVISIONS

Part 1. PREMIUMS

A. PREMIUM CHARGES

The premium rate charged on each Premium Due Date will be an aggregate amount based on the sum of the premiums due for all Members and their Dependents insured under the Group Policy. The Premium Due Date is shown on the cover of the Group Policy.

B. PREMIUM RATE

The premium rate will be determined on the basis set forth in the Policy Data sheet attached to the Group Policy.

The Initial Premium Rate is guaranteed for the Initial Policy Term shown on the Cover Page of the Group Policy.

C. CONTRIBUTIONS FROM MEMBERS

Insurance for each Member and the Dependents of each Member, if any, will be on a Voluntary basis. The basis for the contribution and the amount of the contribution applicable to each Member and their Dependents, if any, is determined by the Policyholder.

D. CHANGES IN PREMIUM RATES

1. Premium rates may be changed at any time upon mutual agreement between the Policyholder and us.
2. If the number of insured Members changes by 15% or more, we may change any one or more of the premium rates on any Premium Due Date, but not more than once in any 12 month period.
3. We may change any one or more premium rates at any time when a change in any law or governmental regulation affects the amount payable by us under this Group Policy. Any such change in premium rates will reflect only the change in our obligations under the Group Policy.
4. Except as provided in 1, 2, or 3 above, we will not change the premium rates during the Initial Policy Term or more than once in any Contract Year thereafter. The Initial Policy Term is shown on the cover of this Group Policy. Contract Years are successive 12 month periods computed from the end of the Initial Policy Term.

We will give the Policyholder prior written notice of any change in the premium rates at least 31 days before the Premium Due Date on which the change will be effective. This notice will be mailed to the Policyholder's last address as shown on our records.

E. PAYMENT OF PREMIUMS

All premiums are due on the Premium Due Dates shown on the cover of the Group Policy. Each premium is payable on or before the premium due date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Group Policy in force through the date immediately preceding the next Premium Due Date.

F. GRACE PERIOD

The Group Policy has a 31 day Grace Period for each premium due after the first premium. If a premium is not paid on or before the Premium Due Date, the premium may be paid during the 31 day Grace Period. The Group Policy will remain in force during the Grace Period. Premiums are due for any coverage provided during the Grace Period.

G. TERMINATION OF GROUP POLICY FOR NONPAYMENT OF PREMIUMS

If the required premium is not paid during the Grace Period, the Group Policy will terminate automatically at 12:01 A.M. on the date following the end of the Grace Period. Premiums are due for any coverage provided during the Grace Period. Termination of this Group Policy for nonpayment of premiums will not influence a Member's right to a claim for benefits which arose prior to the termination.

H. TERMINATION OF GROUP POLICY BY THE POLICYHOLDER

The Policyholder may terminate the Group Policy and the Insurance under the Group Policy at any time by giving prior written notice to us. The effective date of the termination will be the later of:

1. The date specified in the notice; and
2. The date we receive the notice.

No coverage under the Group Policy will continue and no premium charges will accrue after the effective date of the termination of the Group Policy.

I. TERMINATION OF GROUP POLICY BY US

We may terminate the Group Policy as follows:

1. On the first day after the end of any Contract Year at 12:01 A.M. Standard Time.
2. On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number.
3. On any Premium Due Date if we, in our sole judgment, determine that the Policyholder has:
 - a. Failed to promptly furnish any necessary information requested by us.
 - b. Failed to perform any other obligations relating to this Group Policy.
 - c. The decision to terminate this policy will be made in accordance with the terms of this policy, subject to the laws of the state where this policy was issued and federal laws.
4. On any Premium Due Date after the Policyholder ceases to qualify for Insurance in accordance with our standard underwriting rules and practices.

However, we will not terminate the Group Policy for any reason other than non-payment of premium during the Initial Policy Term. We will give the Policyholder at least 60 days prior written notice of any such termination of the Group Policy. Termination of this Group Policy by us will not influence a Member's right to a claim for benefits which arose prior to the termination.

J. PREMIUM ADJUSTMENTS

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 month period immediately preceding the date we receive a request for premium adjustment and evidence that an adjustment should be made.

Part 2. CERTIFICATES

We will make a certificate available to the Insured Member. Certificates will state the insurance protection to which He is entitled and to whom the benefits are payable.

Part 3. RECORDS AND REPORTS

The Policyholder must furnish on our forms all information reasonably necessary to the administration of the Insurance under the Group Policy when required by us.

Clerical error by the Policyholder will not:

1. Cause a Member to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 4. ENTIRE CONTRACT; CHANGES

The Group Policy, including all the endorsements and attached papers, if any, constitute the entire contract between the parties.

The Group Policy may be changed in whole or in part. No change in this Group Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to the Group Policy. No agent has authority to change this Group Policy or to waive any of its provisions.

The Policyholder acts on its own behalf or on the behalf of eligible Members. Under no circumstances will the Policyholder be deemed to act as our agent. The Policyholder does not have the authority to change the Group Policy or to waive any of its provisions, except through a formal amendment as described in the prior paragraph.

Part 5. EFFECT ON WORKER'S COMPENSATION

The coverage provided under the Group Policy is not a substitute for worker's compensation insurance.

SECTION TWO - COVERAGE PROVISIONS

Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF MEMBER

You must be a Member. You are a Member if you are all of the following:

1. Enrolled and part of a business, professional or trade Group.
2. A citizen or resident of the United States.

B. ELIGIBILITY FOR INSURANCE

You are eligible for Insurance on the later of the following dates if you are a Member on that date:

1. The effective date of the Group Policy.
2. The date you become a Member.

C. APPLICATION FOR INSURANCE

You may apply for Insurance or for a change in the Insurance option you selected during the following periods:

1. Within 31 days after the date you first become eligible for Insurance.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 31 days after a Life Event.

You cannot apply for Insurance or for a change in your Insurance option at any other time.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

If you meet the requirements of Parts 1A through 1C, your Insurance will become effective on:

- a. The date you become eligible for Insurance, if you apply on or before or within 31 days after the date you become eligible for Insurance.
 - b. The first day of calendar month following the Open Enrollment Period, if applicable.
 - c. The date of a Life Event, if you apply within 31 days of the Life Event.
2. Effective date of changes in the amount of your Insurance:

Changes in the amount of your Insurance become effective on the date of the change.

Your Insurance will not become effective prior to the effective date of the Group Policy.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.
2. You must have one or more eligible Dependents.
3. You must apply for Insurance on your eligible Dependents.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your spouse. Your spouse must not be separated from you and must meet the requirements of a spouse as defined by the laws of the state in which you reside.
2. Your unmarried child from birth through the date your child becomes 25* years of age. The term "child" includes a natural child, a step-child residing in your home, a child who has been placed with you for adoption by a court of competent jurisdiction, and any other child you support (a) who is chiefly dependent upon you for support and maintenance; (b) who lives with you in a parent-child relationship, (c) whose parent is your child and is insured as a Dependent under the Group Policy; or (d) who is the subject of a Qualified Medical Child Support Order.

The term "child" also includes a step-foster child residing in your home; a grandchild, niece or nephew for whom you have assumed primary care even if the legal guardian of the child is not insured under the Group Policy.

"Primary care" means that you provide food, clothing, and shelter on a regular and continuous basis for a child.

3. Your unmarried child who is 19* or older but under 25* years of age and who is a registered student in full-time attendance at an accredited educational institution.
4. The term "Dependent" does not include: (a) a spouse legally divorced or separated from you, except when coverage is required by a valid court order; (b) a spouse that no longer meets the requirements of A., 1. above; (c) a spouse that does not meet the requirements of a spouse as defined in the State in which you reside; (d) any child for whom a petition for adoption has been denied; or (e) any child in the custody of the state until the final decree of adoption.

* A Dependent child's Insurance may be continued beyond these dates if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. See Part 8.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.
2. You may not insure a Dependent for Insurance unless the Dependent is a citizen or resident of the United States.
3. You may not insure your Dependent for Insurance if your Dependent is a full-time member of the armed forces of any country.
4. You may not insure your Dependent for Insurance if your Dependent is also eligible for Insurance as a Member.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, or you are a party to a suit in which you seek to adopt the child, and any other child you support is eligible from the date of birth, adoption, placement or residence.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must apply for Insurance on your Dependents and agree to pay the entire cost by signing a completed Enrollment Form.

You are only permitted to apply for Insurance on your Dependents during one of the following periods:

1. Within 90 days after you first acquire the Dependent.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 90 days after a Life Event.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.
2. The date you first acquire a Dependent.

You must apply for Insurance on your Dependents. The Insurance on your Dependents will become effective:

1. On the date they become eligible, if you apply for Insurance on your Dependents on or before or within 90 days after that date.
2. On the first day of the month following the Open Enrollment Period, if applicable.
3. On the date of a Life Event.

We will not refuse:

1. To insure a child under the Group Policy on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.
2. To insure an otherwise eligible child under the Group Policy if the child is presumed to be the natural child of the insured.

A Dependent confined to a hospital or any other institution when that person's Insurance would normally begin will be insured on discharge. This limitation does not apply to a child at birth, an adopted child, or a child subject to court ordered child support.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, you are a party to a suit in which you seek to adopt the child, and any other child you support is automatically covered from the date of birth, adoption, placement or residence for 90 days. In order to continue the child's coverage beyond this period you must apply for Insurance on the child and pay the required premium, if any, within 90 days of the date of birth, adoption, placement, or residence.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

Regardless of any other provision in the Group Policy, we will comply with any Qualified Medical Child Support Order (QMCSO) to the extent required by law. Upon receipt of a Medical Child Support Order we will promptly notify you and each Alternative Recipient that we have received the Medical Child Support Order and have adopted procedures for determining whether the Medical Child Support Order is, in fact, a QMCSO. Those procedures include notifying you, and each Alternative Recipient, that each Alternative Recipient will have the right to designate a representative to receive all communications regarding the Alternative Recipient's rights to receive benefits under the Group Policy.

We will, within a reasonable period of time, determine whether the Medical Child Support Order is a QMCSO. If the Medical Child Support Order is a QMCSO, the Alternative Recipient designated in the order will be treated as the insured Member for purposes of payment of benefits under the Group Policy and the reporting and disclosure requirements under ERISA. For example, if benefits would otherwise be payable under the plan to you on account of Covered Expenses relating to an Alternate Recipient, those benefits would be paid directly to the Alternate Recipient or his or her custodial parent or legal guardian.

Any Alternate Recipient, not already Insured as a Dependent, who is the subject of a Medical Child Support Order will be eligible, and may be enrolled, for Insurance under the Group Policy on the date we determine the order is a QMCSO. On that date we will:

1. Permit the child's parent to enroll the child for Insurance without regard to any enrollment season restrictions;
2. Permit the child's other parent, the state department of social and health services, or other agency appointed by a court of competent jurisdiction pursuant to the order, to enroll the child for Insurance, if the child's parent is enrolled but fails to make application to obtain Insurance for the child; and
3. Not terminate the child's Insurance, unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled for comparable vision coverage through another carrier which will take effect not later than the effective date of the termination of the child's insurance, or the Employer has eliminated family vision coverage for all of its Members.

Nothing in the provisions of a QMCSO will require the Group Policy to provide any type or form of benefits, or any option, pursuant to the order that is not already provided under the Group Policy, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822).

Part 3. SCHEDULE OF BENEFITS

Subject to all the terms of the Group Policy, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either an In-Network or an Out-of-Network Provider for Covered Expenses. If an In-Network Provider is used, you will only be billed for the difference between the applicable Co-payment, if any, shown below and the Scheduled Fee for the Covered Expense. Use of an Out-of-Network Provider may result in additional charges. Out-of-Network Providers may bill you for the difference between the Allowance shown below and the Provider's actual charge for the eye examination and materials.

A. FREQUENCY OF USE

Eye Examination Once every 12 months.
 Materials One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every [12 or 24] months and frame every [12 or 24] months.

B. IN-NETWORK BENEFITS

	<u>Co-payment *</u>
Eye Examination	[0 to \$25.00]
Materials	
Eyeglasses (lenses and frames)	[0 to \$25.00]
Contact Lenses	
Soft Standard Daily Wear	[0 to \$25.00]
Disposable / Planned Replacement (Initial Supply)	[0 to \$25.00]
Medically Necessary Contact Lens - (Keratoconus)	[0 to \$25.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid at the same level as for Non-Medically Necessary Contact Lenses.

- * Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.
- ** Frames other than Davis Vision's Fashion, Designer or Premier Collections will be paid up to a maximum of \$60.00. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Designer or Premium Collection there is an additional co-payment; see "Optional In-Network Items" below.
- *** Contact lenses other than Standard, Soft, Daily Wear or Disposable / Planned Replacement contact lenses will be paid up to a maximum of \$50.00. The balance, if any is the Covered Person's responsibility.

Plan Level

Fashion Plan Eyewear from Davis Vision's Fashion Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Designer or Premier Collection. All Optional In-Network Items are subject to the applicable Co-payment.

<u>Optional In-Network Items</u>	<u>Co-payment</u>
Designer Frames	\$15.00
Premier Frames	\$40.00
Glass Grey #3 prescription lenses	\$11.00
Fashion, sun and gradient tinted plastic lenses	\$11.00
Scratch Resistant Coating	\$20.00
Ultra Violet Coating	\$12.00
Anti-Reflective Coating	
Standard Types	\$35.00
Premium Types	\$48.00
Progressive Addition Multifocal Lenses	
Standard Types	\$50.00
Premium Types	\$90.00
Intermediate Vision Lenses	\$30.00
Blended Segment Lenses	\$20.00
Polycarbonate Lenses	\$30.00*
High index lenses	\$55.00
Polarized lenses	\$75.00
Photogrey Extra (photosensitive) glass lenses	\$20.00
Plastic Photosensitive lenses	\$65.00

* no co-payment for children up to age 19 or monocular patients.

C. OUT-OF-NETWORK BENEFITS

A Covered Person may use the Provider of their choice for the following covered vision services. Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

	Allowance *
Eye Examination	[\$40.00]
Materials:	
Frames	[\$45.00]
Lenses:	
Single Vision	[\$40.00]
Bifocal	[\$60.00]
Trifocal	[\$80.00]
Lenticular	[\$80.00]
Contact Lenses	[\$105.00]

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are the Covered Person's responsibility.

Medically Necessary Contact Lens - (Keratoconus) [\$225.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be the Covered Person's responsibility.

D. LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)	
Maximum per Evaluation		\$300.00
Maximum per Follow-up Visit		\$100.00
Low Vision Aids		
Maximum per Aid	\$600.00	
Lifetime Maximum for all Aids	\$1,200.00	

Note this program is available both in and out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be the Covered Person's responsibility.

Part 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while the you or your Dependents, if any, are insured for these benefits. The benefits payable under the Group Policy vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Case history - chief complaint, eye and vision history, medical history
2. Entrance distance acuities
3. External ocular evaluation including slit lamp examination
4. Internal ocular examination
5. Tonometry
6. Distance refraction - objective and subjective
7. Binocular coordination and ocular motility evaluation
8. Evaluation of pupillary function
9. Biomicroscopy
10. Gross visual fields
11. Assessment and plan
12. Advise a Covered Person on matters pertaining to vision care.
13. Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. Benefits under the Group Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Fashion Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:
 - a. Oversized lenses
 - b. Cataract lenses
 - c. Contact lenses

The above materials are subject to the Co-payment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items. These materials are subject to the Co-payment for Optional In-Network Items shown in Part 3:
 - a. Glass Grey #3 prescription lenses
 - b. Fashion, sun and gradient tinted plastic lenses
 - c. Progressive addition lenses
 - d. Photogrey Extra (photosensitive) glass lenses
 - e. Scratch Resistant Coating
 - f. ARC (Anti-Reflective Coating)
 - g. Blended Segment Bifocal Lenses
 - h. Ultraviolet Coating
 - i. Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals)
 - j. High index lenses
 - k. Plastic Photosensitive Lenses
 - l. Polarized lenses
 - m. Intermediate Vision Lenses
 - n. Premier Frames
 - o. Designer Frames

Frames and lenses from an Out-of-Network Provider or from an In-Network Providers own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in Part 3. Schedule of Benefits.

Medically necessary contact lenses prescribed for a Covered Person affected with Keratoconus are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Benefits are payable up to the allowance, subject to the maximum shown in Part 3 for the Covered Expense.

Covered Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
- Follow-up visits.
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be your responsibility.

Part 5. EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For services or supplies not recommended by a Provider.
2. For periodic vision examinations, except as provided for in Part 3.
3. For eye examinations required by a Employer as a condition of employment.
4. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
5. For lenses which do not provide vision correction.
6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.
7. For sickness or injury covered by a workers' compensation act or other similar legislation.
8. Incurred as a direct or indirect result of war (declared or undeclared).
9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
10. For services or supplies furnished to a Covered Person before the effective date of the Group Policy or after the date a Covered Person's Insurance ends.
11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
12. For any medical treatment rendered outside the United States.
13. For services rendered by practitioners who do not meet the definition of Provider.

14. For expenses covered by:
 - a. Any other group insurance.
 - b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.
15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.
16. For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

Part 6. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or
2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

1. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 4, "Effect on the Benefits of This Plan."

2. Definitions

- a. "Plan" means any of the following which provides benefits or services for, or because of, medical or vision care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
 - (3) "Plan" does not include school accident-type coverage, individual contracts of coverage, some supplemental sickness and accident policies, or the medical benefits coverage in a group, group-type, and individual motor vehicle "nofault" and traditional automobile "fault" type contracts. Each contract or other arrangement for coverage under (1) or (2) is a separate plan.

If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

- b. "This Plan" is the part of the Group Policy that provides benefits for vision care expenses.
- c. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.
- d. "Allowable Expense" means a necessary, reasonable and customary item of expense for vision care when the item of expense is covered by This Plan. However, This Plan is not required to pay for a service, supply, or treatment which is not covered by the Group Policy. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and benefit paid.
- e. "Benefit reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.
- f. "Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide.
- g. "Complying plan" means a plan with benefit determination requirements that comply with the requirements of the jurisdiction where the policy was issued.
- h. "Coordination of benefits" means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- i. "Non-complying plan" means a plan with no benefit determination requirements or whose benefit determination requirements do not comply with the requirements of the jurisdiction in which the policy was issued.

3. Order of Benefit Determination Rules

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:
 - (1) the other plan has rules coordinating its benefits with those of This Plan; and
 - (2) both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other plan.
- b. This Plan determines its order of benefits using the first of the following rules which applies:
 - (1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (a) secondary to the plan covering the person as a Dependent; and
 - (b) primary to the plan covering the person as other than a Dependent (e.g. a retired employee).
 - (2) Benefits for a Dependent child whose parents are not separated or divorced will be determined as follows:
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Benefits for a Dependent child whose parents are divorced or separated will be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:
 - (a) If the specific terms of the court decree state that one of the parents is responsible for the vision care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent will be the Secondary Plan.
 - (b) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child will be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (a) nor (b) applies, the order of benefits will be determined in the following order:

- (i) the plan of the parent with custody of the child;
- (ii) the plan of the spouse of the parent with the custody of the child;
- (iii) the plan of the parent not having custody of the child; and
- (iv) the plan of the spouse of the parent not having custody of the child.

- 4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's Dependent) will be determined before the benefits under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.

- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

- a. This section applies when, in accordance with 3, "Order of Benefit Determines Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. The other plan or plans are referred to as "the other plans" in "b" below.
- b. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
 - (1) The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this except as required by law in the state that this policy is issued. Each person claiming benefits under This Plan must give us any facts we need to pay the claim. Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

- a. the persons it has paid or for whom it has paid;
- b. another plan; or
- c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes of the state in which the Policy is delivered or issued for delivery, the provision is automatically amended to meet the minimum requirements of such statutes.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

Your Insurance under the Group Policy will end automatically on the earliest of the following dates:

1. The date you cease to be a Member, as defined in Part 1A, your benefits will end at the end of that month.
2. The date you become a full time member of the armed forces of any country.
3. The date the Group Policy terminates.
4. On the last day of the last period for which you make the required contribution for your Insurance, if you contribute toward the cost of your Insurance.
5. The date you cease to be an enrolled Member of the entity that holds the Group Policy.

Part 8. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.
2. The date the person ceases to be your Dependent, as defined in Part 2A.
3. The date your Dependent becomes a full time member of the armed forces of any country.
4. On the last day of the last period for which you made the required contribution for Insurance on your Dependents.

Continued Coverage For A Handicapped Child:

Insurance on a Dependent child will not end solely because the child ceases to be a Dependent as defined in Part 2 if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child.

Insurance on a Handicapped Child will end automatically on the earliest of the following dates:

1. The date the child becomes capable of self-sustaining employment.
2. The date the child ceases to be chiefly dependent upon you for support and maintenance.
3. The date the Handicapped Child marries.
4. The date coverage would end under this Part 8 for any reason other than the child's attainment of the limiting age.

Part 9. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You and your Dependents, if any, may become insured again under the Group Policy after Insurance ends. The general rule is that you and your Dependents, if any, may become insured again on the same basis as a new Member, as provided in Parts 1 and 2. However, for purposes of becoming insured again, the following rules will apply:

1. If Insurance ends because you cease to be a Member, you and your Dependents, if any, will be immediately eligible for Insurance if you become a Member again within 90 days after your Insurance ends. If you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible for Insurance again the person or persons applying for Insurance will not be eligible until the next Open Enrollment Period, if applicable.
2. If your Insurance ends because you become a full time member of the armed forces of the United States, you will not be required to satisfy any eligibility waiting period shown in Part 1B again.
3. If Insurance ends because you fail to make the required premium contribution, you and your Dependents, if any, will not be eligible until the next Open Enrollment Period, if applicable.
4. If you did not apply for Insurance within 31 days after becoming eligible again and experience a Life Event, you and your Dependents, if any, will be immediately eligible for Insurance. However, if you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible again due to a change in family status you may not apply until the next Open Enrollment Period, if applicable.

Insurance which becomes effective again will not be retroactive to the date the Insurance ended.

Part 10. PAYMENT OF CLAIMS

A. PAPERLESS SYSTEM

The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the examination takes place. The Provider will submit Covered Person's claim directly to Davis Vision.

B. PAYMENT OF BENEFITS

All in-network benefits will be paid directly to the Provider. Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor, or otherwise not competent to give a valid release, we may pay the indemnity to an amount not exceeding \$1,000 to any of your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

C. NOTICE OF CLAIM

Written notice of a claim must be given to Davis Vision within 60 days after the incurred date of the Covered Expense or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Davis Vision directly by the Provider on behalf of the Covered Person.

D. CLAIM FORMS

All claims for benefits should be submitted on our forms. All claims for out-of-network benefits should be submitted on our forms. You or the Provider should obtain claim forms from the Policyholder, Citizens Security Life Insurance Company or Davis Vision. If we fail to provide you with claim forms within 15 days of your request, you:

1. May submit your claim in a letter stating the medical expense for which the claim is made.
2. Will be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

E. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to us at your expense. No benefits for such charges will be paid until we receive satisfactory written proof:

1. That a Covered Person has incurred a Covered Expense.
2. That the charges for which benefits are claimed are not subject to any exclusion.
3. That a Covered Person's Insurance under the Group Policy was in effect on the date the charge was incurred.
4. Of such additional information as we reasonably require in connection with the claim for benefits.

You must provide your written authorization for us to obtain the records and information needed to evaluate your eligibility for benefits. Such proof must be given to us within 90 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

Failure to provide written proof of a loss within the 12 month period will not invalidate or reduce a claim if:

- a. it was not reasonably possible to provide written proof of the loss within that time; or
- b. written proof of the loss is provided as soon as reasonably possible.

Claims not filed within these time limits will be denied and no benefits will be paid. These time limits will not apply during any period when a Covered Person lacked the legal capacity to file a claim.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

Subject to satisfactory written proof of loss, any benefits payable under the Group Policy will be paid within 30 days of our written receipt of such proof of loss, or our initial notice of decision of claim, if later.

G. INDEPENDENT EXAMINATION

We have the right to have a Provider of our choice examine you or your covered insured Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your covered insured Dependent fail to permit or cooperate with a review by the Provider of our choice.

H. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

I. CHILD SUPPORT PAYMENTS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either the parent sharing custody, or temporary control, of the child as may be necessary for the child to obtain benefits;
2. Permit either the parent sharing custody, or temporary control, of the child, or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and
3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

J. ASSIGNMENT

No assignment of interest under the Group Policy will be binding upon us unless and until the original or a duplicate is received at our home office, or by our authorized representative. We do not assume any responsibility for the validity of an assignment.

K. LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part 11. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.
2. Your misrepresentation is contained in a written instrument signed by you.
3. You or your beneficiary have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for three years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be a Member and (2) submit and have approved an Enrollment Form.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if the truth had been known.
2. The misrepresentation is contained in a written instrument signed by the Policyholder.
3. A copy of the written instrument has been given to the Policyholder.

The validity of the Group Policy will not be contested after it has been in effect for three years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 12. CLERICAL ERROR

Clerical error by the Policyholder will not:

1. Cause you to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 13. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we will administer claims through Davis Vision and to interpret the Group Policy and resolve all questions arising in Davis Vision's administration, interpretation, and application of the Group Policy. Our authority includes, but is not limited to, the following:

1. The right to have Davis Vision resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the Group Policy by Davis Vision and any claim under it.
3. The right to have Davis Vision determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

Part 14. GENERAL DEFINITIONS

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Group Policy as the participant's eligible Dependent. For purposes of the benefits provided under the Group Policy, an Alternate Recipient will be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a participant.

ALLOWANCE The flat dollar amount payable under the Group Policy for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

APPLICATION The written request of a duly authorized representative for Insurance under the Group Policy on a form acceptable to us.

CALENDAR YEAR The twelve month period beginning on January 1st and ending on December 31st.

CLAIM This term means a request that benefits of a plan be provided or paid, and the benefits claimed may be in the form of: (a) Services including supplies; (b) Payment for all or a portion of the expenses incurred; (c) a combination of (a) and (b); or (d) An indemnification.

COPAYMENT The amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Co-payments, if applicable, are shown in Part 3. Schedule of Benefits.

COVERED DEPENDENT A Member's Dependent insured under the Group Policy.

COVERED EXPENSE An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Group Policy.

COVERED PERSON means a Member insured under the Group Policy or a Member's Dependent insured under the Group Policy.

CUSTODIAL PARENT The term means the parent awarded custody of a child by a court decree, or with whom the child resides more than one-half (1/2) of the calendar year.

EFFECTIVE DATE The date shown on the cover page. This is the date on which the Group Policy becomes effective.

ENROLLMENT, ENROLLMENT FORM The written request for enrollment in the plan of Insurance by an eligible person on a form acceptable to us.

GROUP means the Policyholder to which the Policy is issued.

GROUP POLICY means our group policy issued to the Policyholder.

HANDICAPPED CHILD means your unmarried child who, on and after the date the child ceases to be a Dependent, is both: (1) continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a Dependent; and (2) continuously chiefly dependent upon you for support and maintenance. Your child will be considered chiefly dependent upon you for support and maintenance during any period when your child is institutionalized because of mental retardation or physical handicap.

INDIVIDUAL CERTIFICATE means a certificate that states the insurance protection to which an Insured Person is entitled and to whom the benefits are payable. We will make a certificate available to the Insured Member.

IN-NETWORK PROVIDER Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE The group vision care insurance provided to you and your Dependents, if any, under the Group Policy.

INSURANCE CONTRACT The term means a policy contract issued by a qualified insurer.

INSURED MEMBER means the Group Member who has insurance coverage under this Policy.

LIFE EVENT One of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse.

MATERIALS Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

MEDICAL CHILD SUPPORT ORDER This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act Sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822) with respect to a group health plan.

MEMBER means a person who is enrolled and part of a business, professional or trade Group.

OPEN ENROLLMENT PERIOD The period of time, established by the Policyholder, during which you have an opportunity to select your benefits and your Dependent's benefits for the coming year.

OPTIONAL IN-NETWORK ITEMS Materials provided under the Group Policy that can be selected at the Covered Person's option, subject to a Co-payment, if any, shown in Part 3. Schedule of Benefits.

OUT-OF-NETWORK PROVIDER Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

POLICYHOLDER The legal entity to whom the Group Policy is issued.

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided. The Group Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or eligible Dependent is entitled under the Group Policy. In order for such an order to be a QMCSO, it must clearly specify:

1. the name and last known mailing address (if any) of the participant and the name and mailing address of each the Alternate Recipient covered by the order;
2. a reasonable description of the type of coverage to be provided under the Group Policy to each Alternate Recipient, or the manner in which that type of coverage is to be determined;
3. the period of coverage to which the order applies; and
4. each plan to which the order applies.

RIDER/ENDORSEMENT A formal document, signed by one of our authorized officers and attached to the Group Policy or a Certificate of Insurance issued under the Group Policy, that amends the Group Policy to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

USUAL AND CUSTOMARY CHARGE That portion of a charge, as determined by us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

VOLUNTARY means you elect and pay the entire cost of your Insurance. The Insurance on your Dependents is Voluntary if you elect and pay the entire cost of your Dependent's Insurance. You must enroll for both your and your Dependents Insurance.

WE, US, OUR OR THE COMPANY With respect to group vision insurance benefits, the insurance company identified on the cover page.

GROUP INSURANCE CERTIFICATE
CITIZENS VISION BENEFIT PLAN

UNDERWRITTEN AND ISSUED BY
CITIZENS SECURITY LIFE INSURANCE COMPANY
12910 SHELBYVILLE ROAD, SUITE 300, LOUISVILLE, KY 40243
1-800-843-7752

Citizens Security Life Insurance Company certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy.

COVERAGE IS ADMINISTERED AND CLAIMS PAID BY
DAVIS VISION PLAN

159 Express Street
Plainview, NY 11803
1-800-999-5431

POLICYHOLDER: [Group Name]
POLICY NUMBER: [Group Number]
POLICY EFFECTIVE DATE: [January 1, 2007]
POLICY ANNIVERSARY: [January 1st]
POLICY ANNIVERSARY DATE: [January 1, 2008]
PREMIUM DUE DATE: [1st to the 15th of each month]
INITIAL TERM: [12 to 36 months]
POLICY DELIVERED IN: Arkansas and governed by the laws of that State

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate of Insurance has a Table of Contents to help you find specific provisions. "You" and "your" refer to the insured Member. "We", "us", and "our" refer to Citizens Security Life Insurance Company. Other defined terms are printed with an initial capital letter.

Signed on Behalf of Citizens Security Life Insurance Company:



John Cornett, President



James T. Helton, Executive Vice President

Member Certificate of Coverage

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Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF MEMBER

You must be a Member. You are a Member if you are all of the following:

1. Enrolled and part of a business, professional or trade Group.
2. A citizen or resident of the United States.

B. ELIGIBILITY FOR INSURANCE

You are eligible for Insurance on the later of the following dates if you are a Member on that date:

1. The effective date of the Group Policy.
2. The date you become a Member.

C. APPLICATION FOR INSURANCE

Your Insurance is Voluntary. If you wish to become insured, you must apply for Insurance by signing a completed Enrollment Form and agree to make the required premium payments.

You may apply for Insurance or for a change in the Insurance option you selected during the following periods:

1. Within 31 days after the date you first become eligible for Insurance.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 31 days after a Life Event.

You cannot apply for Insurance or for a change in your Insurance option at any other time.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

If you meet the requirements of Parts 1A through 1C, your Insurance will become effective on:

- a. The date you become eligible for Insurance, if you apply on or before or within 31 days after the date you become eligible for Insurance.
 - b. The first day of calendar month following the Open Enrollment Period, if applicable.
 - c. The date of a Life Event, if you apply within 31 days of the Life Event.
2. Effective date of changes in the amount of your Insurance:

Changes in the amount of your Insurance become effective on the date of the change.

Your Insurance will not become effective prior to the effective date of the Group Policy.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.
2. You must have one or more eligible Dependents.
3. You must apply for Insurance on your eligible Dependents.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your spouse. Your spouse must not be legally separated from you and must meet the legal requirements of a spouse as defined by the laws of the state in which you reside.
2. Your unmarried child from birth through the date your child becomes 25* years of age. The term "child" includes a natural child, a step-child residing in your home, a child who has been placed with you for adoption by a court of competent jurisdiction, and any other child you support (a) who is chiefly dependent upon you for support and maintenance; (b) who lives with you in a parent-child relationship, (c) whose parent is your child and is insured as a Dependent under the Group Policy; or (d) who is the subject of a Qualified Medical Child Support Order.

The term "child" also includes a step-foster child residing in your home; a grandchild, niece or nephew for whom you have assumed primary care even if the legal guardian of the child is not insured under the Group Policy.

"Primary care" means that you provide food, clothing, and shelter on a regular and continuous basis for a child.

3. Your unmarried child who is 19* or older but under 25* years of age and who is a registered student in full-time attendance at an accredited educational institution.
4. The term "Dependent" does not include: (a) a spouse legally divorced or separated from you, except when coverage is required by a valid court order; (b) a spouse that no longer meets the requirements of A., 1. above; (c) a spouse that does not meet the legal requirements of a spouse as defined in the State in which you reside; (d) any child for whom a petition for adoption has been denied; or (e) any child in the custody of the state until the final decree of adoption.

* A Dependent child's Insurance may be continued beyond these dates if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. See Part 8.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.
2. You may not insure a Dependent for Insurance unless the Dependent is a citizen or resident of the United States.
3. You may not insure your Dependent for Insurance if your Dependent is a full-time member of the armed forces of any country.
4. You may not insure your Dependent for Insurance if your Dependent is also eligible for Insurance as a Member.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, or you are a party to a suit in which you seek to adopt the child, and any other child you support is eligible from the date of birth, adoption, placement or residence.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must apply for Insurance on your Dependents and agree to pay the entire cost by signing a completed Enrollment Form.

You are only permitted to apply for Insurance on your Dependents during one of the following periods:

1. Within 90 days after you first acquire the Dependent.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 90 days after a Life Event.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.
2. The date you first acquire a Dependent.

You must apply for Insurance on your Dependents. The Insurance on your Dependents will become effective:

1. On the date they become eligible, if you apply for Insurance on your Dependents on or before or within 90 days after that date.
2. On the first day of the month following the Open Enrollment Period, if applicable.
3. On the date of a Life Event.

We will not refuse:

1. To insure a child under the Group Policy on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.
2. To insure an otherwise eligible child under the Group Policy if the child is presumed to be the natural child of the insured.

A Dependent confined to a hospital or any other institution when that person's Insurance would normally begin will be insured on discharge. This limitation does not apply to a child at birth, an adopted child, or a child subject to court ordered child support.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, you are a party to a suit in which you seek to adopt the child, and any other child you support is automatically covered from the date of birth, adoption, placement or residence for 90 days. In order to continue the child's coverage beyond this period you must apply for Insurance on the child and pay the required premium, if any, within 90 days of the date of birth, adoption, placement, or residence.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

Regardless of any other provision in the Group Policy, we will comply with any Qualified Medical Child Support Order (QMCSO) to the extent required by law. Upon receipt of a Medical Child Support Order we will promptly notify you and each Alternative Recipient that we have received the Medical Child Support Order and have adopted procedures for determining whether the Medical Child Support Order is, in fact, a QMSO. Those procedures include notifying you, and each Alternative Recipient, that each Alternative Recipient will have the right to designate a representative to receive all communications regarding the Alternative Recipient's rights to receive benefits under the Group Policy.

We will, within a reasonable period of time, determine whether the Medical Child Support Order is a QMCSO. If the Medical Child Support Order is a QMCSO, the Alternative Recipient designated in the order will be treated as the insured Member for purposes of payment of benefits under the Group Policy and the reporting and disclosure requirements under ERISA. For example, if benefits would otherwise be payable under the plan to you on account of Covered Expenses relating to an Alternate Recipient, those benefits would be paid directly to the Alternate Recipient or his or her custodial parent or legal guardian.

Any Alternate Recipient, not already Insured as a Dependent, who is the subject of a Medical Child Support Order will be eligible, and may be enrolled, for Insurance under the Group Policy on the date we determine the order is a QMCSO. On that date we will:

1. Permit the child's parent to enroll the child for Insurance without regard to any enrollment season restrictions;
2. Permit the child's other parent, the state department of social and health services, or other agency appointed by a court of competent jurisdiction pursuant to the order, to enroll the child for Insurance, if the child's parent is enrolled but fails to make application to obtain Insurance for the child; and
3. Not terminate the child's Insurance, unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled for comparable vision coverage through another carrier which will take effect not later than the effective date of the termination of the child's insurance, or the Policyholder has eliminated family vision coverage for all of its Members.

Nothing in the provisions of a QMCSO will require the Group Policy to provide any type or form of benefits, or any option, pursuant to the order that is not already provided under the Group Policy, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822).

Part 3. SCHEDULE OF BENEFITS

Subject to all the terms of the Group Policy, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either an In-Network or an Out-of-Network Provider for Covered Expenses. If an In-Network Provider is used, you will only be billed for the difference between the applicable Copayment, if any, shown below and the Scheduled Fee for the Covered Expense. Use of an Out-of-Network Provider may result in additional charges. Out-of-Network Providers may bill you for the difference between the Allowance shown below and the Provider's actual charge for the eye examination and materials.

A. FREQUENCY OF USE

Eye Examination	Once every 12 months.
Materials	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every [12 or 24] months and frame every [12 or 24] months.

B. IN-NETWORK BENEFITS

Eye Examination	Co-payment * [0 to \$25.00]
Materials	
Eyeglasses (lenses and frames)	[0 to \$25.00]
Contact Lenses	
Soft Standard Daily Wear	[0 to \$25.00]
Disposable / Planned Replacement (Initial Supply)	[0 to \$25.00]
Medically Necessary Contact Lens - (Keratoconus)	[0 to \$25.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will be paid at the same level as for non-Medically Necessary Contact Lenses.

- * Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.
- ** Frames other than Davis Vision's Fashion, Designer or Premier Collections will be paid up to a maximum of \$60.00. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Designer or Premium Collection there is an additional copayment; see "Optional In-Network Items" below.
- *** Contact lenses other than Standard, Soft, Daily Wear or Disposable / Planned Replacement contact lenses will be paid up to a maximum of \$50.00. The balance, if any is the Covered Person's responsibility.

Plan Level

Fashion Plan Eyewear from Davis Vision's Fashion Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Designer or Premier Collection. All Optional In-Network Items are subject to the applicable Copayment.

<u>Optional In-Network Items</u>	<u>Copayment</u>
Designer Frames	\$15.00
Premier Frames	\$40.00
Glass Grey #3 prescription lenses	\$11.00
Fashion, sun and gradient tinted plastic lenses	\$11.00
Scratch Resistant Coating	\$20.00
Ultra Violet Coating	\$12.00
Anti-Reflective Coating	
Standard Types	\$35.00
Premium Types	\$48.00
Progressive Addition Multifocal Lenses	
Standard Types	\$50.00
Premium Types	\$90.00
Intermediate Vision Lenses	\$30.00
Blended Segment Lenses	\$20.00
Polycarbonate Lenses	\$30.00*
High index lenses	\$55.00
Polarized lenses	\$75.00
Photogrey Extra (photosensitive) glass lenses	\$20.00
Plastic Photosensitive lenses	\$65.00

* no copayment for children up to age 19 or monocular patients.

C. OUT-OF-NETWORK BENEFITS

A Covered Person may use the Provider of their choice for the following covered vision services. Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

Eye Examination	Allowance *
Materials:	[\$40.00]
Frames	[\$45.00]
Lenses:	
Single Vision	[\$40.00]
Bifocal	[\$60.00]
Trifocal	[\$80.00]
Lenticular	[\$80.00]
Contact Lenses	[\$105.00]

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are the Covered Person's responsibility.

Medically Necessary Contact Lens - (Keratoconus) [\\$225.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will be paid at the same level for non-Medically Necessary Contact Lenses.

D. LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)
Maximum per Evaluation	\$300.00
Maximum per Follow-up Visit	\$100.00
Low Vision Aids	
Maximum per Aid	\$600.00
Lifetime Maximum for all Aids	\$1,200.00

Note this program is available both in and out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be the Covered Person's responsibility.

Part 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while the you or your Dependents, if any, are insured for these benefits. The benefits payable under the Group Policy vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Case history - chief complaint, eye and vision history, medical history
2. Entrance distance acuities
3. External ocular evaluation including slit lamp examination
4. Internal ocular examination
5. Tonometry
6. Distance refraction - objective and subjective
7. Binocular coordination and ocular motility evaluation
8. Evaluation of pupillary function
9. Biomicroscopy
10. Gross visual fields
11. Assessment and plan
12. Advise a Covered Person on matters pertaining to vision care.
13. Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. Benefits under the Group Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Fashion Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:

- a. Oversized lenses
- b. Cataract lenses
- c. Contact lenses

The above materials are subject to the Copayment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items. These materials are subject to the Copayment for Optional In-Network Items shown in Part 3:

- a. Glass Grey #3 prescription lenses
- b. Fashion, sun and gradient tinted plastic lenses
- c. Progressive addition lenses
- d. Photogrey Extra (photosensitive) glass lenses
- e. Scratch Resistant Coating
- f. ARC (Anti-Reflective Coating)
- g. Blended Segment Bifocal Lenses
- h. Ultraviolet Coating
- i. Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals)
- j. High index lenses
- k. Plastic Photosensitive Lenses
- l. Polarized lenses
- m. Intermediate Vision Lenses
- n. Premier Frames
- o. Designer Frames

Frames and lenses from an Out-of-Network Provider or from an In-Network Providers own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in Part 3. Schedule of Benefits.

Medically necessary contact lenses prescribed for a Covered Person affected with Keratoconus are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Benefits are payable up to the allowance, subject to the maximum shown in Part 3 for the Covered Expense.

Covered Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
- Follow-up visits.
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be your responsibility.

Part 5. EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For services or supplies not recommended by a Provider.
2. For periodic vision examinations, except as provided for in Part 3.
3. For eye examinations required by a Employer as a condition of employment.
4. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
5. For lenses which do not provide vision correction.
6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.
7. For sickness or injury covered by a workers' compensation act or other similar legislation.
8. Incurred as a direct or indirect result of war (declared or undeclared).
9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
10. For services or supplies furnished to a Covered Person before the effective date of the Group Policy or after the date a Covered Person's Insurance ends.
11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
12. For any medical treatment rendered outside the United States.
13. For services rendered by practitioners who do not meet the definition of Provider.
14. For expenses covered by:
 - a. Any other group insurance.
 - b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.
15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.
16. For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

Part 6. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or
2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

1. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 4, "Effect on the Benefits of This Plan."

2. Definitions

a. "Plan" means any of the following which provides benefits or services for, or because of, medical or vision care or treatment:

- (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
- (3) "Plan" does not include school accident-type coverage, individual contracts of coverage, some supplemental sickness and accident policies, or the medical benefits coverage in a group, group-type, and individual motor vehicle "nofault" and traditional automobile "fault" type contracts. Each contract or other arrangement for coverage under (1) or (2) is a separate plan.

If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

b. "This Plan" is the part of the Group Policy that provides benefits for vision care expenses.

c. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

d. "Allowable Expense" means a necessary, reasonable and customary item of expense for vision care when the item of expense is covered by This Plan. However, This Plan is not required to pay for a service, supply, or treatment which is not covered by the Group Policy. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and benefit paid.

e. "Benefit reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

f. "Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide

g. "Complying plan" means a plan with benefit determination requirements that comply with the requirements of the jurisdiction where the policy was issued.

h. "Coordination of benefits" means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

- i. “Non-complying plan” means a plan with no benefit determination requirements or whose benefit determination requirements do not comply with the requirements of the jurisdiction in which the policy was issued.

3. Order of Benefit Determination Rules

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:

- (1) the other plan has rules coordinating its benefits with those of This Plan; and
- (2) both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other plan.

- b. This Plan determines its order of benefits using the first of the following rules which applies:

- (1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (a) secondary to the plan covering the person as a Dependent; and
- (b) primary to the plan covering the person as other than a Dependent (e.g. a retired employee).

- (2) Benefits for a Dependent child whose parents are not separated or divorced will be determined as follows:

- (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
- (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Benefits for a Dependent child whose parents are divorced or separated will be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:

- (a) If the specific terms of the court decree state that one of the parents is responsible for the vision care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent will be the Secondary Plan.
- (b) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child will be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (a) nor (b) applies, the order of benefits will be determined in the following order:

- (i) the plan of the parent with custody of the child;
- (ii) the plan of the spouse of the parent with the custody of the child;
- (iii) the plan of the parent not having custody of the child; and
- (iv) the plan of the spouse of the parent not having custody of the child.

- (4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's Dependent) will be determined before the benefits under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

- a. This section applies when, in accordance with 3, "Order of Benefit Determines Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. The other plan or plans are referred to as "the other plans" in "b" below.
- b. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
 - (1) The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this except as required by law in which this certificate is issued. Each person claiming benefits under This Plan must give us any facts we need to pay the claim. Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

- a. the persons it has paid or for whom it has paid;
- b. another plan; or
- c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes of the state in which the Policy is delivered or issued for delivery, the provision is automatically amended to meet the minimum requirements of such statutes.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

Your Insurance under the Group Policy will end automatically on the earliest of the following dates:

1. The date you cease to be a Member as defined in Part 1A, your benefits will end at the end of that month.
2. The date you become a full time member of the armed forces of any country.
3. The date the Group Policy terminates.
4. On the last day of the last period for which you make the required contribution for your Insurance.

Part 8. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.
2. The date the person ceases to be your Dependent, as defined in Part 2A.
3. The date your Dependent becomes a full time member of the armed forces of any country.
4. On the last day of the last period for which you made the required contribution for Insurance on your Dependents.

Continued Coverage For A Handicapped Child:

Insurance on a Dependent child will not end solely because the child ceases to be a Dependent as defined in Part 2 if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child.

Insurance on a Handicapped Child will end automatically on the earliest of the following dates:

1. The date the child becomes capable of self-sustaining employment.
2. The date the child ceases to be chiefly dependent upon you for support and maintenance.
3. The date the Handicapped Child marries.
4. The date coverage would end under this Part 8 for any reason other than the child's attainment of the limiting age.

Part 9. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You and your Dependents, if any, may become insured again under the Group Policy after Insurance ends. The general rule is that you and your Dependents, if any, may become insured again on the same basis as a new Member, as provided in Parts 1 and 2. However, for purposes of becoming insured again, the following rules will apply:

1. If Insurance ends because you cease to be a Member, you and your Dependents, if any, will be immediately eligible for Insurance if you become a Member again within 90 days after your Insurance ends. If you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible for Insurance again the person or persons applying for Insurance will not be eligible until the next Open Enrollment Period, if applicable.

2. If your Insurance ends because you become a full time member of the armed forces of the United States, you will not be required to satisfy any eligibility waiting period shown in Part 1B again.
3. If Insurance ends because you fail to make the required premium contribution, you and your Dependents, if any, will not be eligible until the next Open Enrollment Period, if applicable.
4. If you did not apply for Insurance within 31 days after becoming eligible again and experience a Life Event, you and your Dependents, if any, will be immediately eligible for Insurance. However, if you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible again due to a change in family status you may not apply until the next Open Enrollment Period, if applicable.

Insurance which becomes effective again will not be retroactive to the date the Insurance ended.

Part 10. PAYMENT OF CLAIMS

A. PAPERLESS SYSTEM

The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the examination takes place. The Provider will submit Covered Person's claim directly to Davis Vision.

B. PAYMENT OF BENEFITS

All in-network benefits will be paid directly to the Provider. Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor, or otherwise not competent to give a valid release, we may pay the indemnity to an amount not exceeding \$1,000 to any of your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

C. NOTICE OF CLAIM

Written notice of a claim must be given to Davis Vision within 60 days after the incurred date of the Covered Expense or as soon thereafter as reasonable possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Davis Vision directly by the Provider on behalf of the Covered Person.

D. CLAIM FORMS

All claims for benefits should be submitted on our forms. All claims for out-of-network benefits should be submitted on our forms. You or the Provider should obtain claim forms from the Policyholder, Citizens Security Life Insurance Company or Davis Vision. If we fail to provide you with claim forms within 15 days of your request, you:

1. May submit your claim in a letter stating the medical expense for which the claim is made.
2. Will be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

E. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to us at your expense. No benefits for such charges will be paid until we receive satisfactory written proof:

1. That a Covered Person has incurred a Covered Expense.
2. That the charges for which benefits are claimed are not subject to any exclusion.
3. That a Covered Person's Insurance under the Group Policy was in effect on the date the charge was incurred.
4. Of such additional information as we reasonably require in connection with the claim for benefits.

You must provide your written authorization for us to obtain the records and information needed to evaluate your eligibility for benefits. Such proof must be given to us within 90 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

Failure to provide written proof of a loss within the 12 month period will not invalidate or reduce a claim if:

- a. it was not reasonably possible to provide written proof of the loss within that time; or
- b. written proof of the loss is provided as soon as reasonably possible.

Claims not filed within these time limits will be denied and no benefits will be paid. These time limits will not apply during any period when a Covered Person lacked the legal capacity to file a claim.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

Subject to satisfactory written proof of loss, any benefits payable under the Group Policy will be paid within 30 days of our written receipt of such proof of loss, or our initial notice of decision of claim, if later.

G. INDEPENDENT EXAMINATION

We have the right to have a Provider of our choice examine you or your covered insured Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your covered insured Dependent fail to permit or cooperate with a review by the Provider of our choice.

H. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

I. CHILD SUPPORT PAYMENTS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either the parent sharing custody, or temporary control, of the child as may be necessary for the child to obtain benefits;
2. Permit either the parent sharing custody, or temporary control, of the child, or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and
3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

J. ASSIGNMENT

No assignment of interest under the Group Policy will be binding upon us unless and until the original or a duplicate is received at our home office, or by our authorized representative. We do not assume any responsibility for the validity of an assignment.

K. LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part 11. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.
2. Your misrepresentation is contained in a written instrument signed by you.
3. You or your beneficiary have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for three years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be a Member and (2) submit and have approved an Enrollment Form.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if the truth had been known.
2. The misrepresentation is contained in a written instrument signed by the Policyholder.
3. A copy of the written instrument has been given to the Policyholder.

The validity of the Group Policy will not be contested after it has been in effect for three years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 12. CLERICAL ERROR

Clerical error by the Policyholder will not:

1. Cause you to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 13. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we will administer claims and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. Our authority includes, but is not limited to, the following:

1. The right to resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it.
3. The right to determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

Part 14. GENERAL DEFINITIONS

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Group Policy as the participant's eligible Dependent. For purposes of the benefits provided under the Group Policy, an Alternate Recipient will be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a participant.

ALLOWANCE The flat dollar amount payable under the Group Policy for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

APPLICATION The written request of a duly authorized representative for Insurance under the Group Policy on a form acceptable to us.

CALENDAR YEAR The twelve month period beginning on January 1st and ending on December 31st.

CLAIM This term means a request that benefits of a plan be provided or paid, and the benefits claimed may be in the form of: (a) Services including supplies; (b) Payment for all or a portion of the expenses incurred; (c) a combination of (a) and (b); or (d) An indemnification.

COPAYMENT The amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in Part 3. Schedule of Benefits.

COVERED DEPENDENT A Member's Dependent insured under the Group Policy.

COVERED EXPENSE An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Group Policy.

COVERED PERSON means a Member insured under the Group Policy or a Member's Dependent insured under the Group Policy.

CUSTODIAL PARENT The term means the parent awarded custody of a child by a court decree, or with whom the child resides more than one-half (1/2) of the calendar year.

EFFECTIVE DATE The date shown on the cover page. This is the date on which the Group Policy becomes effective.

ENROLLMENT, ENROLLMENT FORM The written request for enrollment in the plan of Insurance by an eligible person on a form acceptable to us.

GROUP means the Policyholder to which the Policy is issued.

GROUP POLICY means our group policy number issued to the Policyholder.

HANDICAPPED CHILD means your unmarried child who, on and after the date the child ceases to be a Dependent, is both: (1) continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a Dependent; and (2) continuously chiefly dependent upon you for support and maintenance. Your child will be considered chiefly dependent upon you for support and maintenance during any period when your child is institutionalized because of mental retardation or physical handicap.

INDIVIDUAL CERTIFICATE means a certificate that states the insurance protection to which an Insured Person is entitled and to whom the benefits are payable. We will make a certificate available to the Insured Member.

IN-NETWORK PROVIDER Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE The group vision care insurance provided to you and your Dependents, if any, under the Group Policy.

INSURANCE CONTRACT The term means a policy contract issued by a qualified insurer.

INSURED MEMBER means the Group Member who has insurance coverage under this Policy.

LIFE EVENT One of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse.

MATERIALS Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

MEDICAL CHILD SUPPORT ORDER This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act Sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822) with respect to a group health plan.

MEMBER means a person who is enrolled and part of a business, professional or trade Group.

OPEN ENROLLMENT PERIOD The period of time, established by the Policyholder, during which you have an opportunity to select your benefits and your Dependent's benefits for the coming year.

OPTIONAL IN-NETWORK ITEMS Materials provided under the Group Policy that can be selected at the Covered Person's option, subject to a Copayment, if any, shown in Part 3. Schedule of Benefits.

OUT-OF-NETWORK PROVIDER Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

POLICYHOLDER The legal entity to whom the Group Policy is issued.

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided. The Group Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or eligible Dependent is entitled under the Group Policy. In order for such an order to be a QMCSO, it must clearly specify:

1. the name and last known mailing address (if any) of the participant and the name and mailing address of each the Alternate Recipient covered by the order;
2. a reasonable description of the type of coverage to be provided under the Group Policy to each Alternate Recipient, or the manner in which that type of coverage is to be determined;
3. the period of coverage to which the order applies; and
4. each plan to which the order applies.

RIDER/ENDORSEMENT A formal document, signed by one of our authorized officers and attached to the Group Policy or a Certificate of Insurance issued under the Group Policy, that amends the Group Policy to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

USUAL AND CUSTOMARY CHARGE That portion of a charge, as determined by us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

VOLUNTARY means you elect and pay the entire cost of your Insurance. The Insurance on your Dependents is Voluntary if you elect and pay the entire cost of your Dependent's Insurance. You must enroll for both your and your Dependents Insurance.

WE, US, OUR OR THE COMPANY With respect to group vision insurance benefits, the insurance company identified on the cover page.

SERFF Tracking Number: *CSLI-126151728* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *42386*
Company Tracking Number:
TOI: *H20G Group Health - Vision* *Sub-TOI:* *H20G.000 Health - Vision*
Product Name: *Group Vision - Associations & Labor Unions*
Project Name/Number: *Group Vision - ASSC & LBUN/*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CSLI-126151728 State: Arkansas
Filing Company: Citizens Security Life Insurance Company State Tracking Number: 42386
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Group Vision - Associations & Labor Unions
Project Name/Number: Group Vision - ASSC & LBUN/

Supporting Document Schedules

Satisfied -Name: COVER LETTER	Review Status: Approved-Closed	05/28/2009
Comments: 2 Cover Letter details changes made.		
Attachments: Cover Ltr.pdf 2 Cover Ltr.pdf		
Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachment: Readability Cert.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/28/2009
Comments: ATTACHED FOR INFORMATIONAL PURPOSES; APPLICATIONS BEING FILED WITH SERFF # CSLI-126151657		
Attachments: Form ASLU APP GLA 01 09.pdf Form ASLU ENR GLA 01 09.pdf		
Satisfied -Name: STATEMENTS OF VARIABILITY	Review Status: Approved-Closed	05/28/2009
Comments:		
Attachments: ASLU MAST GPA 02 09 St. of Variability.pdf ASLU CERT GPA 02 09 St. of Variability.pdf		



May 13, 2009

Arkansas Department of Insurance
Health Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC#-61921 FEIN# 61-0648389
Form # ASLU MAST GPA 02 09 AR; Group Vision Master Policy
ASLU CERT GPA 02 09 AR; Group Vision Certificate

Dear Sir/Madam:

Enclosed please find our group vision product for your review and approval. These are new policy forms and will not replace any existing forms.

Our group products are marketed by brokers and independent agents. This vision product will be a companion product to our group life and group dental products which are being filed concurrently with this filing, but under a separate SERFF number.

These forms will be marketed to Associations and Labor Unions on a voluntary basis.

The applications that will be used with this vision product are form # ASLU APP GLA 01 09 AR and form # ASLU ENR GLA 01 09 AR, which are being filed with the group life product.

A Statement of Variability is attached to the Master Policy and Certificate.

If you should have any questions concerning this filing, please contact me at (800) 843-7752 or e-mail rbolduc@cslico.com. Your prompt attention to this filing is greatly appreciated.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate



May 20, 2009

Ms. Rosalind Minor
Arkansas Department of Insurance
Health Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Citizens Security Life Insurance Company – **Re-Submission**
NAIC#-61921 FEIN# 61-0648389 SERFF# CSLI-126151728
Form # ASLU MAST GPA 02 09 AR; Group Vision Master Policy
ASLU CERT GPA 02 09 AR; Group Vision Certificate

Dear Ms. Minor:

Thank you for your letter dated May 19, 2009 regarding the above noted filing. I have reviewed your comments and made the necessary changes.

In compliance with ACA 23-86-108(4) and Bulletin 14-81, we have revised the Dependent sections of the forms pertaining to “the time limit of furnishing proof of incapacity”. The changes are on page 19 of the master and page 14 of the certificate.

If you should have any further questions concerning this filing or need additional information, please contact me at (800) 843-7752 or e-mail rbolduc@cslico.com. Thank you for your help with this filing.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate

Citizens Security Life Insurance Company
12910 Shelbyville Road, Suite 300
Louisville, KY 40243

Readability Certification

I, James Helton, Executive Vice President, Group Products, Citizens Security Life Insurance Company, hereby certify that the following forms have a Flesch Scale readability score of:

ASLU MAST GPA 02 09 AR; Group Vision Master Policy – 52.3
ASLU CERT GPA 02 09 AR; Group Vision Certificate – 50.9

I also certify, to the best of my knowledge and belief, the form is in compliance with the statutes and regulations for simplified and readability policy forms of the state for which it is being filed.

Signed for: Citizens Security Life Insurance Company

Date: May 5, 2009

By: 

Title: Executive Vice President,
Group Products

GROUP INSURANCE MASTER APPLICATION

POLICYHOLDER INFORMATION			
Policyholder Name:		Federal Tax ID:	
Address:			
City:	State:	Zip Code:	Phone #:
Group Contact:	Email Address:		Fax #:
Nature of the Group:			
COVERAGE REQUESTED (PLEASE CHECK ALL THAT APPLY)			
<i>Application must be accompanied by a copy of the Proposal Rate Page for the selected coverage(s).</i>			
<input type="checkbox"/> Dental	<input type="checkbox"/> Dependent Spouse.	<input type="checkbox"/> Dependent Child.	
<input type="checkbox"/> Vision	<input type="checkbox"/> Dependent Spouse.	<input type="checkbox"/> Dependent Child.	
<input type="checkbox"/> Life	<input type="checkbox"/> Dependent Family (Spouse and Child(ren))		
<input type="checkbox"/> Accidental Death and Dismemberment (<i>Member ONLY</i>)			
PLAN INFORMATION			
Plan Effective Date (Requested):		Eligibility Period Waived For Initial Enrollment (Y/N)?	
Total Number of Members:		Total Number of Members Enrolled:	
Eligibility Period for New Members:		First of the Month Following:	Other:
I Agree to Accept Electronic Delivery of the Policy and Certificates. <input type="checkbox"/> Yes <input type="checkbox"/> No			
AUTHORIZATION			
<p>I hereby authorize CITIZENS SECURITY LIFE INSURANCE to issue a Group Policy(ies) and Certificates for coverage as listed above. The effective date of coverage shall be as listed above; provided that final data submitted is satisfactory for the issuance of the policy(ies) requested. I also agree to administer the program(s) for the Members and to make premium payments, if appropriate.</p> <p><i>Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</i></p>			
Authorized Signature:		Title:	Date:
Agent's Signature:			Date:
Agent's Printed Name:		Agent No:	

GROUP ENROLLMENT APPLICATION

Citizens Security Life Insurance Company
P.O.Box 436149, Louisville, KY 40253-6149

New Enrollment **Change**

Part I – To be Completed by Policyholder (Please Print)				
Group No.	Group Name.	Date of Group Membership:		
Part II – Coverage Election (eligibility for Dependent Insurance requires Member Coverage)				
VOLUNTARY LIFE	DENTAL	VISION		
Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No. Coverage Amount \$ _____.	Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Member: <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Dependent Family (spouse & children): <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Spouse: <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Spouse: <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Spouse Coverage Amount \$ _____.	Dependent Child(ren): <input type="checkbox"/> Yes. <input type="checkbox"/> No.	Dependent Child(ren): <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Child(ren) Coverage Amount \$ _____.				
Part III – To be Completed by Member (Please Print)				
Member Name. (Last, First, MI).		Date of Birth.	Age.	<input type="checkbox"/> Male. <input type="checkbox"/> Married. <input type="checkbox"/> Female. <input type="checkbox"/> Single.
Street Address.	City.	State.	Zip Code.	Social Security Number.
List all Eligible Dependents to be insured under this application (Please Print)				
Name of Dependent.	Relationship.	Sex.	Date of Birth.	Social Security Number.
Beneficiary Information for Member’s Coverage (Member is the beneficiary of proceeds on Spouse and Child(ren) insurance)				
Primary. (First, Middle, Last).	Soc Sec No.	Date of Birth.	Allocation %	Relationship.
Contingent. (First, Middle, Last).	Soc Sec No.	Date of Birth.	Allocation %	Relationship.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby request to be insured for benefits to which I may be entitled under the Group Policy (ies) issued to the Policyholder listed above. For the coverage I have declined, I understand that if I choose to enroll at a later date, my cost may be higher, Evidence of Insurability may be required or coverage may be denied.

I hereby declare that all answers above are true and complete to the best of my knowledge and belief.

Signature of Member. _____ Date. _____

Signature of Spouse. _____ Date. _____

Signature of Dependent(s) (Age 19 & older). _____ Date. _____

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security's Vision Benefit Plan
Form ASLU MAST GPA 02 09 AR

I. Front Page – Page 1

- a. Policyholder name will change with each policy issued.
- b. Policy Number will change with each group issued.
- c. Effective Date will be given a date of issue ranging from the 1st through the 15th of the month. The date will depend upon the request of the policyholder at time the application is taken.
- d. Policy Anniversary will reflect the month of the year and day of the month of the policy's anniversary date.
- e. Policy Anniversary Date will reflect the first policy anniversary date following the issue of the group policy.
- f. Premium Due Date will reflect the day of the month premiums are due; 1st to the 15th.
- g. Initial Term is the period of time that the policy will remain in force before it will be renewed.

II. Policy Data Page – Page 2

- a. Rate per month per member- varies by benefits selected, gender make-up of group, the industry, and the location of the group; range \$3.00-\$12.50.
- b. Rate per month per member plus spouse-- varies by benefits selected, gender make-up of group, the industry and the location of the group; range \$6.00-\$25.00.
- c. Rate per month per member plus children-- varies by benefits selected, gender make-up of group, the industry, and the location of the group; range \$6.00-\$25.00.
- d. Rate per month per member plus family-- varies by benefits selected, gender make-up of group, the industry, and the location of the group; range \$9.00-\$50.00.
- e. Initial Term is the period of time that the policy will remain in force before it will be renewed; 12, 24 or 36 months.
- f. We will list the Minimum Participation Number needed for the Group Policy to remain inforce; range 5+.

III. Schedule of Benefits – Page 11 & 12

- A. Frequency of use-materials—the policyholder selects at time of application to have a 12 month and/or 24 month on replacement of lenses or frames.

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security's Vision Benefit Plan
Form ASLU MAST GPA 02 09 AR

- B. In-network Benefits
- i. Eye-examinations— co-payments can range from \$0 to \$25.00.
 - ii. Materials:
 - a. Eyeglasses (lenses & frames)-- co-payments can range from \$0 to \$25.00.
 - b. Soft contact lenses-- co-payments can range from \$0 to \$25.00.
 - c. Disposable contact lenses-- co-payments can range from \$0 to \$25.00.
 - iii. Medically necessary contact lens co-payments can range from \$0 to \$25.00.

Optional In-Network Items: Co-payments will vary:

i.	Designer Frames	range \$0.00 -\$50.00
ii.	Premier Frames	range \$0.00 -\$50.00
iii.	Glass Grey #3 prescription lenses	range \$0.00 -\$50.00
iv.	Fashion, sun and gradient tinted plastic lenses	range \$0.00 -\$50.00
v.	Scratch Resistant Coating	range \$0.00 -\$50.00
vi.	Ultra Violet Coating	range \$0.00 -\$50.00
vii.	Anti-Reflective Coating	
viii.	Standard Types	range \$0.00 -\$50.00
ix.	Premium Types	range \$0.00 -\$50.00
x.	Progressive Addition Multifocal Lenses	
	Standard Types	range \$0.00-\$100.00
	Premium Types	range \$0.00-\$100.00
xi.	Intermediate Vision Lenses	range \$0.00-\$100.00
xii.	Blended Segment Lenses	range \$0.00-\$100.00
xiii.	Polycarbonate Lenses	range \$0.00-\$100.00
xiv.	High index lenses	range \$0.00-\$100.00
xv.	Polarized lenses	range \$0.00-\$100.00
xvi.	Photogrey Extra (photosensitive) glass lenses	range \$0.00-\$100.00
xvii.	Plastic Photosensitive lenses	range \$0.00-\$100.00

- C. Out-of-network Allowance
- i. Eye examinations-- can range from \$20 to \$80
 - ii. Materials:
 - a. Frames-- can range from \$20 to \$90
 - b. Lenses:
 - (i) Single Vision-- can range from \$20 to \$80
 - (ii) Bifocal--can range from \$30 to \$120
 - (iii) Trifocal--can range from \$40 to \$160
 - (iv) Lenticular--can range from \$40 to \$160
 - c. Contact Lenses-- can range from \$55 to \$210
 - d. Medically necessary Contact Lenses-- can range from \$110 to \$250

- D. Low Vision Program
- i. Comprehensive Evaluation Once every 60 months (includes four follow-up visits)
 - i. Maximum per Evaluation range \$150.00-\$600.00
 - ii. Maximum per Follow-up Visit range \$50.00-\$200.00
 - ii. Low Vision Aids
 - i. Maximum per Aid range \$300.00-\$1200.00
 - ii. Lifetime Maximum for all Aids range \$600.00-\$2400.00

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security's Vision Benefit Plan
Form ASLU CERT GPA 02 09 AR

I. Front Page – Page 1

- a. Policyholder name will change with each policy issued.
- b. Policy Number will change with each group issued.
- c. Effective Date will be given a date of issue ranging from the 1st through the 15th of the month. The date will depend upon the request of the policyholder at time the application is taken.
- d. Policy Anniversary will reflect the month of the year and day of the month of the policy's anniversary date.
- e. Policy Anniversary Date will reflect the first policy anniversary date following the issue of the group policy.
- f. Premium Due Date will reflect the day of the month premiums are due; 1st to the 15th.
- g. Initial Term is the period of time that the policy will remain in force before it will be renewed.

II. Schedule of Benefits – Page 6 & 7 & 8

- A. Frequency of use-materials—the policyholder selects at time of application to have a 12 month and/or 24 month on replacement of lenses or frames.
- B. In-network Benefits – Page 11
 - i. Eye-examinations— co-payments can range from \$0 to \$25.00.
 - ii. Materials:
 - a. Eyeglasses (lenses & frames)-- co-payments can range from \$0 to \$25.00.
 - b. Soft contact lenses-- co-payments can range from \$0 to \$25.00.
 - c. Disposable contact lenses-- co-payments can range from \$0 to \$25.00.
 - iii. Medically necessary contact lens co-payments can range from \$0 to \$25.00.

Optional In-Network Items: Co-payments will vary:

i.	Designer Frames	range \$0.00 -\$50.00
ii.	Premier Frames	range \$0.00 -\$50.00
iii.	Glass Grey #3 prescription lenses	range \$0.00 -\$50.00
iv.	Fashion, sun and gradient tinted plastic lenses	range \$0.00 -\$50.00
v.	Scratch Resistant Coating	range \$0.00 -\$50.00
vi.	Ultra Violet Coating	range \$0.00 -\$50.00
vii.	Anti-Reflective Coating	
viii.	Standard Types	range \$0.00 -\$50.00
ix.	Premium Types	range \$0.00 -\$50.00
x.	Progressive Addition Multifocal Lenses	
	Standard Types	range \$0.00-\$100.00
	Premium Types	range \$0.00-\$100.00
xi.	Intermediate Vision Lenses	range \$0.00-\$100.00
xii.	Blended Segment Lenses	range \$0.00-\$100.00
xiii.	Polycarbonate Lenses	range \$0.00-\$100.00
xiv.	High index lenses	range \$0.00-\$100.00
xv.	Polarized lenses	range \$0.00-\$100.00
xvi.	Photogrey Extra (photosensitive) glass lenses	range \$0.00-\$100.00
xvii.	Plastic Photosensitive lenses	range \$0.00-\$100.00

CITIZENS SECURITY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
Citizens Security's Vision Benefit Plan
Form ASLU CERT GPA 02 09 AR

C. Out-of-network Allowance

- i. Eye examinations-- can range from \$20 to \$80
- ii. Materials:
 - a. Frames-- can range from \$20 to \$90
 - b. Lenses:
 - (i) Single Vision-- can range from \$20 to \$80
 - (ii) Bifocal--can range from \$30 to \$120
 - (iii) Trifocal--can range from \$40 to \$160
 - (iv) Lenticular--can range from \$40 to \$160
 - c. Contact Lenses-- can range from \$55 to \$210
 - d. Medically necessary Contact Lenses-- can range from \$110 to \$250

D. Low Vision Program – Page 12

- i. Comprehensive Evaluation Once every 60 months (includes four follow-up visits)
 - i. Maximum per Evaluation range \$150.00-\$600.00
 - ii. Maximum per Follow-up Visit range \$50.00-\$200.00
- ii. Low Vision Aids
 - i. Maximum per Aid range \$300.00-\$1200.00
 - ii. Lifetime Maximum for all Aids range \$600.00-\$2400.00

SERFF Tracking Number: *CSLI-126151728* *State:* *Arkansas*
Filing Company: *Citizens Security Life Insurance Company* *State Tracking Number:* *42386*
Company Tracking Number:
TOI: *H20G Group Health - Vision* *Sub-TOI:* *H20G.000 Health - Vision*
Product Name: *Group Vision - Associations & Labor Unions*
Project Name/Number: *Group Vision - ASSC & LBUN/*

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	GROUP VISION MASTER POLICY	05/14/2009	Form ASLU MAST GPA 02 09.pdf
No original date	Form	GROUP VISION CERTIFICATE	05/14/2009	Form ASLU CERT GPA 02 09.pdf
No original date	Supporting Document	COVER LETTER	05/14/2009	Cover Ltr.pdf

CITIZENS VISION BENEFIT PLAN

UNDERWRITTEN and ISSUED BY
CITIZENS SECURITY LIFE INSURANCE COMPANY
12910 SHELBYVILLE ROAD, SUITE 300, LOUISVILLE, KY 40243
1-800-843-7752

ADMINISTERED and CLAIMS PAID BY

DAVIS VISION PLAN

159 Express Street
Plainview, NY 11803
1-800-999-5431

POLICYHOLDER: [Group Name]
POLICY NUMBER: [Group Number]
POLICY EFFECTIVE DATE: [January 1, 2007]
POLICY ANNIVERSARY: [January 1st]
POLICY ANNIVERSARY DATE: [January 1, 2008]
PREMIUM DUE DATE: [1st to the 15th of each month]
INITIAL TERM: [12 to 36 months]
POLICY DELIVERED IN: Arkansas and governed by the laws of that State

Citizens Security Life Insurance Company agrees to pay the benefits provided under this Group Policy through its Administrator, Davis Vision Plan, upon satisfactory written proof of loss with respect to each insured Member or each insured Dependent of a Member in accordance with the provisions of this Group Policy. The consideration for this Group Policy is the application of the Policyholder and the payment of the required premiums as they become due.

All periods indicated in this Group Policy begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

All provisions on this and the following pages are a part of this Group Policy. A Certificate of Insurance will be made available to the Insured Member and is part of the Group Policy. The definitions of terms in the Certificate of Insurance apply whenever the terms are used anywhere in this Group Policy. The terms "we", "us", "our" and "Company" refer to Citizens Security Life Insurance Company. The Policyholder may add new Members or Dependents from time to time in accordance with the terms of this Group Policy.

Signed on Behalf of Citizens Security Life Insurance Company:



John Cornett
President & COO



James T. Helton, III
Executive Vice President-Group

Group Insurance Policy

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SECTION ONE - POLICYHOLDER PROVISIONS

Part 1. PREMIUMS

A. PREMIUM CHARGES

The premium rate charged on each Premium Due Date will be an aggregate amount based on the sum of the premiums due for all Members and their Dependents insured under the Group Policy. The Premium Due Date is shown on the cover of the Group Policy.

B. PREMIUM RATE

The premium rate will be determined on the basis set forth in the Policy Data sheet attached to the Group Policy.

The Initial Premium Rate is guaranteed for the Initial Policy Term shown on the Cover Page of the Group Policy.

C. CONTRIBUTIONS FROM MEMBERS

Insurance for each Member and the Dependents of each Member, if any, will be on a Voluntary basis. The basis for the contribution and the amount of the contribution applicable to each Member and their Dependents, if any, is determined by the Policyholder.

D. CHANGES IN PREMIUM RATES

1. Premium rates may be changed at any time upon mutual agreement between the Policyholder and us.
2. If the number of insured Members changes by 15% or more, we may change any one or more of the premium rates on any Premium Due Date, but not more than once in any 12 month period.
3. We may change any one or more premium rates at any time when a change in any law or governmental regulation affects the amount payable by us under this Group Policy. Any such change in premium rates will reflect only the change in our obligations under the Group Policy.
4. Except as provided in 1, 2, or 3 above, we will not change the premium rates during the Initial Policy Term or more than once in any Contract Year thereafter. The Initial Policy Term is shown on the cover of this Group Policy. Contract Years are successive 12 month periods computed from the end of the Initial Policy Term.

We will give the Policyholder prior written notice of any change in the premium rates at least 31 days before the Premium Due Date on which the change will be effective. This notice will be mailed to the Policyholder's last address as shown on our records.

E. PAYMENT OF PREMIUMS

All premiums are due on the Premium Due Dates shown on the cover of the Group Policy. Each premium is payable on or before the premium due date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Group Policy in force through the date immediately preceding the next Premium Due Date.

F. GRACE PERIOD

The Group Policy has a 31 day Grace Period for each premium due after the first premium. If a premium is not paid on or before the Premium Due Date, the premium may be paid during the 31 day Grace Period. The Group Policy will remain in force during the Grace Period. Premiums are due for any coverage provided during the Grace Period.

G. TERMINATION OF GROUP POLICY FOR NONPAYMENT OF PREMIUMS

If the required premium is not paid during the Grace Period, the Group Policy will terminate automatically at 12:01 A.M. on the date following the end of the Grace Period. Premiums are due for any coverage provided during the Grace Period. Termination of this Group Policy for nonpayment of premiums will not influence a Member's right to a claim for benefits which arose prior to the termination.

H. TERMINATION OF GROUP POLICY BY THE POLICYHOLDER

The Policyholder may terminate the Group Policy and the Insurance under the Group Policy at any time by giving prior written notice to us. The effective date of the termination will be the later of:

1. The date specified in the notice; and
2. The date we receive the notice.

No coverage under the Group Policy will continue and no premium charges will accrue after the effective date of the termination of the Group Policy.

I. TERMINATION OF GROUP POLICY BY US

We may terminate the Group Policy as follows:

1. On the first day after the end of any Contract Year at 12:01 A.M. Standard Time.
2. On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number.
3. On any Premium Due Date if we, in our sole judgment, determine that the Policyholder has:
 - a. Failed to promptly furnish any necessary information requested by us.
 - b. Failed to perform any other obligations relating to this Group Policy.
 - c. The decision to terminate this policy will be made in accordance with the terms of this policy, subject to the laws of the state where this policy was issued and federal laws.
4. On any Premium Due Date after the Policyholder ceases to qualify for Insurance in accordance with our standard underwriting rules and practices.

However, we will not terminate the Group Policy for any reason other than non-payment of premium during the Initial Policy Term. We will give the Policyholder at least 60 days prior written notice of any such termination of the Group Policy. Termination of this Group Policy by us will not influence a Member's right to a claim for benefits which arose prior to the termination.

J. PREMIUM ADJUSTMENTS

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 month period immediately preceding the date we receive a request for premium adjustment and evidence that an adjustment should be made.

Part 2. CERTIFICATES

We will make a certificate available to the Insured Member. Certificates will state the insurance protection to which He is entitled and to whom the benefits are payable.

Part 3. RECORDS AND REPORTS

The Policyholder must furnish on our forms all information reasonably necessary to the administration of the Insurance under the Group Policy when required by us.

Clerical error by the Policyholder will not:

1. Cause a Member to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 4. ENTIRE CONTRACT; CHANGES

The Group Policy, including all the endorsements and attached papers, if any, constitute the entire contract between the parties.

The Group Policy may be changed in whole or in part. No change in this Group Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to the Group Policy. No agent has authority to change this Group Policy or to waive any of its provisions.

The Policyholder acts on its own behalf or on the behalf of eligible Members. Under no circumstances will the Policyholder be deemed to act as our agent. The Policyholder does not have the authority to change the Group Policy or to waive any of its provisions, except through a formal amendment as described in the prior paragraph.

Part 5. EFFECT ON WORKER'S COMPENSATION

The coverage provided under the Group Policy is not a substitute for worker's compensation insurance.

SECTION TWO - COVERAGE PROVISIONS

Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF MEMBER

You must be a Member. You are a Member if you are all of the following:

1. Enrolled and part of a business, professional or trade Group.
2. A citizen or resident of the United States.

B. ELIGIBILITY FOR INSURANCE

You are eligible for Insurance on the later of the following dates if you are a Member on that date:

1. The effective date of the Group Policy.
2. The date you become a Member.

C. APPLICATION FOR INSURANCE

You may apply for Insurance or for a change in the Insurance option you selected during the following periods:

1. Within 31 days after the date you first become eligible for Insurance.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 31 days after a Life Event.

You cannot apply for Insurance or for a change in your Insurance option at any other time.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

If you meet the requirements of Parts 1A through 1C, your Insurance will become effective on:

- a. The date you become eligible for Insurance, if you apply on or before or within 31 days after the date you become eligible for Insurance.
 - b. The first day of calendar month following the Open Enrollment Period, if applicable.
 - c. The date of a Life Event, if you apply within 31 days of the Life Event.
2. Effective date of changes in the amount of your Insurance:

Changes in the amount of your Insurance become effective on the date of the change.

Your Insurance will not become effective prior to the effective date of the Group Policy.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.
2. You must have one or more eligible Dependents.
3. You must apply for Insurance on your eligible Dependents.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your spouse. Your spouse must not be separated from you and must meet the requirements of a spouse as defined by the laws of the state in which you reside.
2. Your unmarried child from birth through the date your child becomes 25* years of age. The term "child" includes a natural child, a step-child residing in your home, a child who has been placed with you for adoption by a court of competent jurisdiction, and any other child you support (a) who is chiefly dependent upon you for support and maintenance; (b) who lives with you in a parent-child relationship, (c) whose parent is your child and is insured as a Dependent under the Group Policy; or (d) who is the subject of a Qualified Medical Child Support Order.

The term "child" also includes a step-foster child residing in your home; a grandchild, niece or nephew for whom you have assumed primary care even if the legal guardian of the child is not insured under the Group Policy.

"Primary care" means that you provide food, clothing, and shelter on a regular and continuous basis for a child.

3. Your unmarried child who is 19* or older but under 25* years of age and who is a registered student in full-time attendance at an accredited educational institution.
4. The term "Dependent" does not include: (a) a spouse legally divorced or separated from you, except when coverage is required by a valid court order; (b) a spouse that no longer meets the requirements of A., 1. above; (c) a spouse that does not meet the requirements of a spouse as defined in the State in which you reside; (d) any child for whom a petition for adoption has been denied; or (e) any child in the custody of the state until the final decree of adoption.

* A Dependent child's Insurance may be continued beyond these dates if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. See Part 8.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.
2. You may not insure a Dependent for Insurance unless the Dependent is a citizen or resident of the United States.
3. You may not insure your Dependent for Insurance if your Dependent is a full-time member of the armed forces of any country.
4. You may not insure your Dependent for Insurance if your Dependent is also eligible for Insurance as a Member.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, or you are a party to a suit in which you seek to adopt the child, and any other child you support is eligible from the date of birth, adoption, placement or residence.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must apply for Insurance on your Dependents and agree to pay the entire cost by signing a completed Enrollment Form.

You are only permitted to apply for Insurance on your Dependents during one of the following periods:

1. Within 90 days after you first acquire the Dependent.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 90 days after a Life Event.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.
2. The date you first acquire a Dependent.

You must apply for Insurance on your Dependents. The Insurance on your Dependents will become effective:

1. On the date they become eligible, if you apply for Insurance on your Dependents on or before or within 90 days after that date.
2. On the first day of the month following the Open Enrollment Period, if applicable.
3. On the date of a Life Event.

We will not refuse:

1. To insure a child under the Group Policy on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.
2. To insure an otherwise eligible child under the Group Policy if the child is presumed to be the natural child of the insured.

A Dependent confined to a hospital or any other institution when that person's Insurance would normally begin will be insured on discharge. This limitation does not apply to a child at birth, an adopted child, or a child subject to court ordered child support.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, you are a party to a suit in which you seek to adopt the child, and any other child you support is automatically covered from the date of birth, adoption, placement or residence for 90 days. In order to continue the child's coverage beyond this period you must apply for Insurance on the child and pay the required premium, if any, within 90 days of the date of birth, adoption, placement, or residence.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

Regardless of any other provision in the Group Policy, we will comply with any Qualified Medical Child Support Order (QMCSO) to the extent required by law. Upon receipt of a Medical Child Support Order we will promptly notify you and each Alternative Recipient that we have received the Medical Child Support Order and have adopted procedures for determining whether the Medical Child Support Order is, in fact, a QMCSO. Those procedures include notifying you, and each Alternative Recipient, that each Alternative Recipient will have the right to designate a representative to receive all communications regarding the Alternative Recipient's rights to receive benefits under the Group Policy.

We will, within a reasonable period of time, determine whether the Medical Child Support Order is a QMCSO. If the Medical Child Support Order is a QMCSO, the Alternative Recipient designated in the order will be treated as the insured Member for purposes of payment of benefits under the Group Policy and the reporting and disclosure requirements under ERISA. For example, if benefits would otherwise be payable under the plan to you on account of Covered Expenses relating to an Alternate Recipient, those benefits would be paid directly to the Alternate Recipient or his or her custodial parent or legal guardian.

Any Alternate Recipient, not already Insured as a Dependent, who is the subject of a Medical Child Support Order will be eligible, and may be enrolled, for Insurance under the Group Policy on the date we determine the order is a QMCSO. On that date we will:

1. Permit the child's parent to enroll the child for Insurance without regard to any enrollment season restrictions;
2. Permit the child's other parent, the state department of social and health services, or other agency appointed by a court of competent jurisdiction pursuant to the order, to enroll the child for Insurance, if the child's parent is enrolled but fails to make application to obtain Insurance for the child; and
3. Not terminate the child's Insurance, unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled for comparable vision coverage through another carrier which will take effect not later than the effective date of the termination of the child's insurance, or the Employer has eliminated family vision coverage for all of its Members.

Nothing in the provisions of a QMCSO will require the Group Policy to provide any type or form of benefits, or any option, pursuant to the order that is not already provided under the Group Policy, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822).

Part 3. SCHEDULE OF BENEFITS

Subject to all the terms of the Group Policy, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either an In-Network or an Out-of-Network Provider for Covered Expenses. If an In-Network Provider is used, you will only be billed for the difference between the applicable Co-payment, if any, shown below and the Scheduled Fee for the Covered Expense. Use of an Out-of-Network Provider may result in additional charges. Out-of-Network Providers may bill you for the difference between the Allowance shown below and the Provider's actual charge for the eye examination and materials.

A. FREQUENCY OF USE

Eye Examination Once every 12 months.
 Materials One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every [12 or 24] months and frame every [12 or 24] months.

B. IN-NETWORK BENEFITS

	<u>Co-payment *</u>
Eye Examination	[0 to \$25.00]
Materials	
Eyeglasses (lenses and frames)	[0 to \$25.00]
Contact Lenses	
Soft Standard Daily Wear	[0 to \$25.00]
Disposable / Planned Replacement (Initial Supply)	[0 to \$25.00]
Medically Necessary Contact Lens - (Keratoconus)	[0 to \$25.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid at the same level as for Non-Medically Necessary Contact Lenses.

- * Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.
- ** Frames other than Davis Vision's Fashion, Designer or Premier Collections will be paid up to a maximum of \$60.00. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Designer or Premium Collection there is an additional co-payment; see "Optional In-Network Items" below.
- *** Contact lenses other than Standard, Soft, Daily Wear or Disposable / Planned Replacement contact lenses will be paid up to a maximum of \$50.00. The balance, if any is the Covered Person's responsibility.

Plan Level

Fashion Plan Eyewear from Davis Vision's Fashion Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Designer or Premier Collection. All Optional In-Network Items are subject to the applicable Co-payment.

<u>Optional In-Network Items</u>	<u>Co-payment</u>
Designer Frames	\$15.00
Premier Frames	\$40.00
Glass Grey #3 prescription lenses	\$11.00
Fashion, sun and gradient tinted plastic lenses	\$11.00
Scratch Resistant Coating	\$20.00
Ultra Violet Coating	\$12.00
Anti-Reflective Coating	
Standard Types	\$35.00
Premium Types	\$48.00
Progressive Addition Multifocal Lenses	
Standard Types	\$50.00
Premium Types	\$90.00
Intermediate Vision Lenses	\$30.00
Blended Segment Lenses	\$20.00
Polycarbonate Lenses	\$30.00*
High index lenses	\$55.00
Polarized lenses	\$75.00
Photogrey Extra (photosensitive) glass lenses	\$20.00
Plastic Photosensitive lenses	\$65.00

* no co-payment for children up to age 19 or monocular patients.

C. OUT-OF-NETWORK BENEFITS

A Covered Person may use the Provider of their choice for the following covered vision services. Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

	Allowance *
Eye Examination	[\$40.00]
Materials:	
Frames	[\$45.00]
Lenses:	
Single Vision	[\$40.00]
Bifocal	[\$60.00]
Trifocal	[\$80.00]
Lenticular	[\$80.00]
Contact Lenses	[\$105.00]

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are the Covered Person's responsibility.

Medically Necessary Contact Lens - (Keratoconus) [\$225.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be the Covered Person's responsibility.

D. LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)	
Maximum per Evaluation		\$300.00
Maximum per Follow-up Visit		\$100.00
Low Vision Aids		
Maximum per Aid	\$600.00	
Lifetime Maximum for all Aids	\$1,200.00	

Note this program is available both in and out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be the Covered Person's responsibility.

Part 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while the you or your Dependents, if any, are insured for these benefits. The benefits payable under the Group Policy vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Case history - chief complaint, eye and vision history, medical history
2. Entrance distance acuities
3. External ocular evaluation including slit lamp examination
4. Internal ocular examination
5. Tonometry
6. Distance refraction - objective and subjective
7. Binocular coordination and ocular motility evaluation
8. Evaluation of pupillary function
9. Biomicroscopy
10. Gross visual fields
11. Assessment and plan
12. Advise a Covered Person on matters pertaining to vision care.
13. Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. Benefits under the Group Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Fashion Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:
 - a. Oversized lenses
 - b. Cataract lenses
 - c. Contact lenses

The above materials are subject to the Co-payment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items. These materials are subject to the Co-payment for Optional In-Network Items shown in Part 3:
 - a. Glass Grey #3 prescription lenses
 - b. Fashion, sun and gradient tinted plastic lenses
 - c. Progressive addition lenses
 - d. Photogrey Extra (photosensitive) glass lenses
 - e. Scratch Resistant Coating
 - f. ARC (Anti-Reflective Coating)
 - g. Blended Segment Bifocal Lenses
 - h. Ultraviolet Coating
 - i. Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals)
 - j. High index lenses
 - k. Plastic Photosensitive Lenses
 - l. Polarized lenses
 - m. Intermediate Vision Lenses
 - n. Premier Frames
 - o. Designer Frames

Frames and lenses from an Out-of-Network Provider or from an In-Network Providers own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in Part 3. Schedule of Benefits.

Medically necessary contact lenses prescribed for a Covered Person affected with Keratoconus are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Benefits are payable up to the allowance, subject to the maximum shown in Part 3 for the Covered Expense.

Covered Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
- Follow-up visits.
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be your responsibility.

Part 5. EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For services or supplies not recommended by a Provider.
2. For periodic vision examinations, except as provided for in Part 3.
3. For eye examinations required by a Employer as a condition of employment.
4. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
5. For lenses which do not provide vision correction.
6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.
7. For sickness or injury covered by a workers' compensation act or other similar legislation.
8. Incurred as a direct or indirect result of war (declared or undeclared).
9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
10. For services or supplies furnished to a Covered Person before the effective date of the Group Policy or after the date a Covered Person's Insurance ends.
11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
12. For any medical treatment rendered outside the United States.
13. For services rendered by practitioners who do not meet the definition of Provider.

14. For expenses covered by:
 - a. Any other group insurance.
 - b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.
15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.
16. For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

Part 6. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or
2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

1. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 4, "Effect on the Benefits of This Plan."

2. Definitions

- a. "Plan" means any of the following which provides benefits or services for, or because of, medical or vision care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
 - (3) "Plan" does not include school accident-type coverage, individual contracts of coverage, some supplemental sickness and accident policies, or the medical benefits coverage in a group, group-type, and individual motor vehicle "nofault" and traditional automobile "fault" type contracts. Each contract or other arrangement for coverage under (1) or (2) is a separate plan.

If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

- b. "This Plan" is the part of the Group Policy that provides benefits for vision care expenses.
- c. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.
- d. "Allowable Expense" means a necessary, reasonable and customary item of expense for vision care when the item of expense is covered by This Plan. However, This Plan is not required to pay for a service, supply, or treatment which is not covered by the Group Policy. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and benefit paid.
- e. "Benefit reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.
- f. "Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide.
- g. "Complying plan" means a plan with benefit determination requirements that comply with the requirements of the jurisdiction where the policy was issued.
- h. "Coordination of benefits" means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- i. "Non-complying plan" means a plan with no benefit determination requirements or whose benefit determination requirements do not comply with the requirements of the jurisdiction in which the policy was issued.

3. Order of Benefit Determination Rules

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:
 - (1) the other plan has rules coordinating its benefits with those of This Plan; and
 - (2) both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other plan.
- b. This Plan determines its order of benefits using the first of the following rules which applies:
 - (1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (a) secondary to the plan covering the person as a Dependent; and
 - (b) primary to the plan covering the person as other than a Dependent (e.g. a retired employee).
 - (2) Benefits for a Dependent child whose parents are not separated or divorced will be determined as follows:
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Benefits for a Dependent child whose parents are divorced or separated will be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:
 - (a) If the specific terms of the court decree state that one of the parents is responsible for the vision care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent will be the Secondary Plan.
 - (b) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child will be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (a) nor (b) applies, the order of benefits will be determined in the following order:

- (i) the plan of the parent with custody of the child;
- (ii) the plan of the spouse of the parent with the custody of the child;
- (iii) the plan of the parent not having custody of the child; and
- (iv) the plan of the spouse of the parent not having custody of the child.

- 4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's Dependent) will be determined before the benefits under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.

- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

- a. This section applies when, in accordance with 3, "Order of Benefit Determines Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. The other plan or plans are referred to as "the other plans" in "b" below.
- b. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
 - (1) The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this except as required by law in the state that this policy is issued. Each person claiming benefits under This Plan must give us any facts we need to pay the claim. Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

- a. the persons it has paid or for whom it has paid;
- b. another plan; or
- c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes of the state in which the Policy is delivered or issued for delivery, the provision is automatically amended to meet the minimum requirements of such statutes.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

Your Insurance under the Group Policy will end automatically on the earliest of the following dates:

1. The date you cease to be a Member, as defined in Part 1A, your benefits will end at the end of that month.
2. The date you become a full time member of the armed forces of any country.
3. The date the Group Policy terminates.
4. On the last day of the last period for which you make the required contribution for your Insurance, if you contribute toward the cost of your Insurance.
5. The date you cease to be an enrolled Member of the entity that holds the Group Policy.

Part 8. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.
2. The date the person ceases to be your Dependent, as defined in Part 2A.
3. The date your Dependent becomes a full time member of the armed forces of any country.
4. On the last day of the last period for which you made the required contribution for Insurance on your Dependents.

Continued Coverage For A Handicapped Child:

Insurance on a Dependent child will not end solely because the child ceases to be a Dependent as defined in Part 2 if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. This proof must be furnished to us on our forms within 31 days after the child ceases to be a Dependent as defined, and thereafter as required by us, but not more often than once a year after the two year period following the child's attainment of the limiting age. We have the right, at our expense, to have your child examined at reasonable intervals while you are claiming continued coverage under this provision.

Insurance on a Handicapped Child will end automatically on the earliest of the following dates:

1. The date the child becomes capable of self-sustaining employment.
2. The date the child ceases to be chiefly dependent upon you for support and maintenance.
3. 90 days after the date we mail you a request for proof that the child continues to qualify as a Handicapped Child, unless you provide us with the required proof within that 90 day period.
4. The date the Handicapped Child marries.
5. The date coverage would end under this Part 8 for any reason other than the child's attainment of the limiting age.

Part 9. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You and your Dependents, if any, may become insured again under the Group Policy after Insurance ends. The general rule is that you and your Dependents, if any, may become insured again on the same basis as a new Member, as provided in Parts 1 and 2. However, for purposes of becoming insured again, the following rules will apply:

1. If Insurance ends because you cease to be a Member, you and your Dependents, if any, will be immediately eligible for Insurance if you become a Member again within 90 days after your Insurance ends. If you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible for Insurance again the person or persons applying for Insurance will not be eligible until the next Open Enrollment Period, if applicable.
2. If your Insurance ends because you become a full time member of the armed forces of the United States, you will not be required to satisfy any eligibility waiting period shown in Part 1B again.
3. If Insurance ends because you fail to make the required premium contribution, you and your Dependents, if any, will not be eligible until the next Open Enrollment Period, if applicable.
4. If you did not apply for Insurance within 31 days after becoming eligible again and experience a Life Event, you and your Dependents, if any, will be immediately eligible for Insurance. However, if you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible again due to a change in family status you may not apply until the next Open Enrollment Period, if applicable.

Insurance which becomes effective again will not be retroactive to the date the Insurance ended.

Part 10. PAYMENT OF CLAIMS

A. PAPERLESS SYSTEM

The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the examination takes place. The Provider will submit Covered Person's claim directly to Davis Vision.

B. PAYMENT OF BENEFITS

All in-network benefits will be paid directly to the Provider. Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor, or otherwise not competent to give a valid release, we may pay the indemnity to an amount not exceeding \$1,000 to any of your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

C. NOTICE OF CLAIM

Written notice of a claim must be given to Davis Vision within 60 days after the incurred date of the Covered Expense or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Davis Vision directly by the Provider on behalf of the Covered Person.

D. CLAIM FORMS

All claims for benefits should be submitted on our forms. All claims for out-of-network benefits should be submitted on our forms. You or the Provider should obtain claim forms from the Policyholder, Citizens Security Life Insurance Company or Davis Vision. If we fail to provide you with claim forms within 15 days of your request, you:

1. May submit your claim in a letter stating the medical expense for which the claim is made.
2. Will be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

E. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to us at your expense. No benefits for such charges will be paid until we receive satisfactory written proof:

1. That a Covered Person has incurred a Covered Expense.
2. That the charges for which benefits are claimed are not subject to any exclusion.
3. That a Covered Person's Insurance under the Group Policy was in effect on the date the charge was incurred.
4. Of such additional information as we reasonably require in connection with the claim for benefits.

You must provide your written authorization for us to obtain the records and information needed to evaluate your eligibility for benefits. Such proof must be given to us within 90 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

Failure to provide written proof of a loss within the 12 month period will not invalidate or reduce a claim if:

- a. it was not reasonably possible to provide written proof of the loss within that time; or
- b. written proof of the loss is provided as soon as reasonably possible.

Claims not filed within these time limits will be denied and no benefits will be paid. These time limits will not apply during any period when a Covered Person lacked the legal capacity to file a claim.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

Subject to satisfactory written proof of loss, any benefits payable under the Group Policy will be paid within 30 days of our written receipt of such proof of loss, or our initial notice of decision of claim, if later.

G. INDEPENDENT EXAMINATION

We have the right to have a Provider of our choice examine you or your covered insured Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your covered insured Dependent fail to permit or cooperate with a review by the Provider of our choice.

H. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

I. CHILD SUPPORT PAYMENTS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either the parent sharing custody, or temporary control, of the child as may be necessary for the child to obtain benefits;
2. Permit either the parent sharing custody, or temporary control, of the child, or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and
3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

J. ASSIGNMENT

No assignment of interest under the Group Policy will be binding upon us unless and until the original or a duplicate is received at our home office, or by our authorized representative. We do not assume any responsibility for the validity of an assignment.

K. LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part 11. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.
2. Your misrepresentation is contained in a written instrument signed by you.
3. You or your beneficiary have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for three years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be a Member and (2) submit and have approved an Enrollment Form.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if the truth had been known.
2. The misrepresentation is contained in a written instrument signed by the Policyholder.
3. A copy of the written instrument has been given to the Policyholder.

The validity of the Group Policy will not be contested after it has been in effect for three years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 12. CLERICAL ERROR

Clerical error by the Policyholder will not:

1. Cause you to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 13. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we will administer claims through Davis Vision and to interpret the Group Policy and resolve all questions arising in Davis Vision's administration, interpretation, and application of the Group Policy. Our authority includes, but is not limited to, the following:

1. The right to have Davis Vision resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the Group Policy by Davis Vision and any claim under it.
3. The right to have Davis Vision determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

Part 14. GENERAL DEFINITIONS

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Group Policy as the participant's eligible Dependent. For purposes of the benefits provided under the Group Policy, an Alternate Recipient will be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a participant.

ALLOWANCE The flat dollar amount payable under the Group Policy for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

APPLICATION The written request of a duly authorized representative for Insurance under the Group Policy on a form acceptable to us.

CALENDAR YEAR The twelve month period beginning on January 1st and ending on December 31st.

CLAIM This term means a request that benefits of a plan be provided or paid, and the benefits claimed may be in the form of: (a) Services including supplies; (b) Payment for all or a portion of the expenses incurred; (c) a combination of (a) and (b); or (d) An indemnification.

COPAYMENT The amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Co-payments, if applicable, are shown in Part 3. Schedule of Benefits.

COVERED DEPENDENT A Member's Dependent insured under the Group Policy.

COVERED EXPENSE An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Group Policy.

COVERED PERSON means a Member insured under the Group Policy or a Member's Dependent insured under the Group Policy.

CUSTODIAL PARENT The term means the parent awarded custody of a child by a court decree, or with whom the child resides more than one-half (1/2) of the calendar year.

EFFECTIVE DATE The date shown on the cover page. This is the date on which the Group Policy becomes effective.

ENROLLMENT, ENROLLMENT FORM The written request for enrollment in the plan of Insurance by an eligible person on a form acceptable to us.

GROUP means the Policyholder to which the Policy is issued.

GROUP POLICY means our group policy issued to the Policyholder.

HANDICAPPED CHILD means your unmarried child who, on and after the date the child ceases to be a Dependent, is both: (1) continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a Dependent; and (2) continuously chiefly dependent upon you for support and maintenance. Your child will be considered chiefly dependent upon you for support and maintenance during any period when your child is institutionalized because of mental retardation or physical handicap.

INDIVIDUAL CERTIFICATE means a certificate that states the insurance protection to which an Insured Person is entitled and to whom the benefits are payable. We will make a certificate available to the Insured Member.

IN-NETWORK PROVIDER Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE The group vision care insurance provided to you and your Dependents, if any, under the Group Policy.

INSURANCE CONTRACT The term means a policy contract issued by a qualified insurer.

INSURED MEMBER means the Group Member who has insurance coverage under this Policy.

LIFE EVENT One of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse.

MATERIALS Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

MEDICAL CHILD SUPPORT ORDER This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act Sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822) with respect to a group health plan.

MEMBER means a person who is enrolled and part of a business, professional or trade Group.

OPEN ENROLLMENT PERIOD The period of time, established by the Policyholder, during which you have an opportunity to select your benefits and your Dependent's benefits for the coming year.

OPTIONAL IN-NETWORK ITEMS Materials provided under the Group Policy that can be selected at the Covered Person's option, subject to a Co-payment, if any, shown in Part 3. Schedule of Benefits.

OUT-OF-NETWORK PROVIDER Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

POLICYHOLDER The legal entity to whom the Group Policy is issued.

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided. The Group Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or eligible Dependent is entitled under the Group Policy. In order for such an order to be a QMCSO, it must clearly specify:

1. the name and last known mailing address (if any) of the participant and the name and mailing address of each the Alternate Recipient covered by the order;
2. a reasonable description of the type of coverage to be provided under the Group Policy to each Alternate Recipient, or the manner in which that type of coverage is to be determined;
3. the period of coverage to which the order applies; and
4. each plan to which the order applies.

RIDER/ENDORSEMENT A formal document, signed by one of our authorized officers and attached to the Group Policy or a Certificate of Insurance issued under the Group Policy, that amends the Group Policy to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

USUAL AND CUSTOMARY CHARGE That portion of a charge, as determined by us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

VOLUNTARY means you elect and pay the entire cost of your Insurance. The Insurance on your Dependents is Voluntary if you elect and pay the entire cost of your Dependent's Insurance. You must enroll for both your and your Dependents Insurance.

WE, US, OUR OR THE COMPANY With respect to group vision insurance benefits, the insurance company identified on the cover page.

GROUP INSURANCE CERTIFICATE
CITIZENS VISION BENEFIT PLAN

UNDERWRITTEN AND ISSUED BY
CITIZENS SECURITY LIFE INSURANCE COMPANY
12910 SHELBYVILLE ROAD, SUITE 300, LOUISVILLE, KY 40243
1-800-843-7752

Citizens Security Life Insurance Company certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy.

COVERAGE IS ADMINISTERED AND CLAIMS PAID BY
DAVIS VISION PLAN

159 Express Street
Plainview, NY 11803
1-800-999-5431

POLICYHOLDER: [Group Name]
POLICY NUMBER: [Group Number]
POLICY EFFECTIVE DATE: [January 1, 2007]
POLICY ANNIVERSARY: [January 1st]
POLICY ANNIVERSARY DATE: [January 1, 2008]
PREMIUM DUE DATE: [1st to the 15th of each month]
INITIAL TERM: [12 to 36 months]
POLICY DELIVERED IN: Arkansas and governed by the laws of that State

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate of Insurance has a Table of Contents to help you find specific provisions. "You" and "your" refer to the insured Member. "We", "us", and "our" refer to Citizens Security Life Insurance Company. Other defined terms are printed with an initial capital letter.

Signed on Behalf of Citizens Security Life Insurance Company:



John Cornett, President



James T. Helton, Executive Vice President

Member Certificate of Coverage

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Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through D.

A. DEFINITION OF MEMBER

You must be a Member. You are a Member if you are all of the following:

1. Enrolled and part of a business, professional or trade Group.
2. A citizen or resident of the United States.

B. ELIGIBILITY FOR INSURANCE

You are eligible for Insurance on the later of the following dates if you are a Member on that date:

1. The effective date of the Group Policy.
2. The date you become a Member.

C. APPLICATION FOR INSURANCE

Your Insurance is Voluntary. If you wish to become insured, you must apply for Insurance by signing a completed Enrollment Form and agree to make the required premium payments.

You may apply for Insurance or for a change in the Insurance option you selected during the following periods:

1. Within 31 days after the date you first become eligible for Insurance.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 31 days after a Life Event.

You cannot apply for Insurance or for a change in your Insurance option at any other time.

D. EFFECTIVE DATE OF INSURANCE AND CHANGES IN INSURANCE

1. Initial effective date of your Insurance:

If you meet the requirements of Parts 1A through 1C, your Insurance will become effective on:

- a. The date you become eligible for Insurance, if you apply on or before or within 31 days after the date you become eligible for Insurance.
 - b. The first day of calendar month following the Open Enrollment Period, if applicable.
 - c. The date of a Life Event, if you apply within 31 days of the Life Event.
2. Effective date of changes in the amount of your Insurance:

Changes in the amount of your Insurance become effective on the date of the change.

Your Insurance will not become effective prior to the effective date of the Group Policy.

Part 2. INSURING YOUR DEPENDENTS

To insure your Dependents for Insurance, you must meet each of the following requirements:

1. You must be a Member who is insured for Insurance.
2. You must have one or more eligible Dependents.
3. You must apply for Insurance on your eligible Dependents.

A. DEFINITION OF DEPENDENT

DEPENDENT means a person who is:

1. Your spouse. Your spouse must not be legally separated from you and must meet the legal requirements of a spouse as defined by the laws of the state in which you reside.
2. Your unmarried child from birth through the date your child becomes 25* years of age. The term "child" includes a natural child, a step-child residing in your home, a child who has been placed with you for adoption by a court of competent jurisdiction, and any other child you support (a) who is chiefly dependent upon you for support and maintenance; (b) who lives with you in a parent-child relationship, (c) whose parent is your child and is insured as a Dependent under the Group Policy; or (d) who is the subject of a Qualified Medical Child Support Order.

The term "child" also includes a step-foster child residing in your home; a grandchild, niece or nephew for whom you have assumed primary care even if the legal guardian of the child is not insured under the Group Policy.

"Primary care" means that you provide food, clothing, and shelter on a regular and continuous basis for a child.

3. Your unmarried child who is 19* or older but under 25* years of age and who is a registered student in full-time attendance at an accredited educational institution.
4. The term "Dependent" does not include: (a) a spouse legally divorced or separated from you, except when coverage is required by a valid court order; (b) a spouse that no longer meets the requirements of A., 1. above; (c) a spouse that does not meet the legal requirements of a spouse as defined in the State in which you reside; (d) any child for whom a petition for adoption has been denied; or (e) any child in the custody of the state until the final decree of adoption.

* A Dependent child's Insurance may be continued beyond these dates if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. See Part 8.

B. ELIGIBLE DEPENDENTS

Your Dependents are eligible for Insurance, except as follows:

1. You may not insure your Dependents for Insurance unless you are insured for Insurance.
2. You may not insure a Dependent for Insurance unless the Dependent is a citizen or resident of the United States.
3. You may not insure your Dependent for Insurance if your Dependent is a full-time member of the armed forces of any country.
4. You may not insure your Dependent for Insurance if your Dependent is also eligible for Insurance as a Member.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, or you are a party to a suit in which you seek to adopt the child, and any other child you support is eligible from the date of birth, adoption, placement or residence.

C. APPLICATION FOR INSURANCE ON YOUR DEPENDENTS

You must apply for Insurance on your Dependents and agree to pay the entire cost by signing a completed Enrollment Form.

You are only permitted to apply for Insurance on your Dependents during one of the following periods:

1. Within 90 days after you first acquire the Dependent.
2. During the Open Enrollment Period of each Calendar Year, if applicable.
3. Within 90 days after a Life Event.

D. EFFECTIVE DATE OF DEPENDENT INSURANCE

Your Dependents are eligible for Insurance on:

1. The date your Insurance becomes effective.
2. The date you first acquire a Dependent.

You must apply for Insurance on your Dependents. The Insurance on your Dependents will become effective:

1. On the date they become eligible, if you apply for Insurance on your Dependents on or before or within 90 days after that date.
2. On the first day of the month following the Open Enrollment Period, if applicable.
3. On the date of a Life Event.

We will not refuse:

1. To insure a child under the Group Policy on the grounds that the child was born out of wedlock, the child is not claimed as a Dependent on the parent's federal tax return, or the child does not reside with the parent or in our service area.
2. To insure an otherwise eligible child under the Group Policy if the child is presumed to be the natural child of the insured.

A Dependent confined to a hospital or any other institution when that person's Insurance would normally begin will be insured on discharge. This limitation does not apply to a child at birth, an adopted child, or a child subject to court ordered child support.

A newly born child, adopted child, child placed in your home for adoption, stepchild residing in your home, you are a party to a suit in which you seek to adopt the child, and any other child you support is automatically covered from the date of birth, adoption, placement or residence for 90 days. In order to continue the child's coverage beyond this period you must apply for Insurance on the child and pay the required premium, if any, within 90 days of the date of birth, adoption, placement, or residence.

Your Dependents will not be insured before the day your Insurance begins.

E. MEDICAL CHILD SUPPORT ORDERS

Regardless of any other provision in the Group Policy, we will comply with any Qualified Medical Child Support Order (QMCSO) to the extent required by law. Upon receipt of a Medical Child Support Order we will promptly notify you and each Alternative Recipient that we have received the Medical Child Support Order and have adopted procedures for determining whether the Medical Child Support Order is, in fact, a QMSO. Those procedures include notifying you, and each Alternative Recipient, that each Alternative Recipient will have the right to designate a representative to receive all communications regarding the Alternative Recipient's rights to receive benefits under the Group Policy.

We will, within a reasonable period of time, determine whether the Medical Child Support Order is a QMCSO. If the Medical Child Support Order is a QMCSO, the Alternative Recipient designated in the order will be treated as the insured Member for purposes of payment of benefits under the Group Policy and the reporting and disclosure requirements under ERISA. For example, if benefits would otherwise be payable under the plan to you on account of Covered Expenses relating to an Alternate Recipient, those benefits would be paid directly to the Alternate Recipient or his or her custodial parent or legal guardian.

Any Alternate Recipient, not already Insured as a Dependent, who is the subject of a Medical Child Support Order will be eligible, and may be enrolled, for Insurance under the Group Policy on the date we determine the order is a QMCSO. On that date we will:

1. Permit the child's parent to enroll the child for Insurance without regard to any enrollment season restrictions;
2. Permit the child's other parent, the state department of social and health services, or other agency appointed by a court of competent jurisdiction pursuant to the order, to enroll the child for Insurance, if the child's parent is enrolled but fails to make application to obtain Insurance for the child; and
3. Not terminate the child's Insurance, unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, the child is or will be enrolled for comparable vision coverage through another carrier which will take effect not later than the effective date of the termination of the child's insurance, or the Policyholder has eliminated family vision coverage for all of its Members.

Nothing in the provisions of a QMCSO will require the Group Policy to provide any type or form of benefits, or any option, pursuant to the order that is not already provided under the Group Policy, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822).

Part 3. SCHEDULE OF BENEFITS

Subject to all the terms of the Group Policy, we will pay for Covered Expenses incurred by a Covered Person as shown below.

You and your Covered Dependents may use either an In-Network or an Out-of-Network Provider for Covered Expenses. If an In-Network Provider is used, you will only be billed for the difference between the applicable Copayment, if any, shown below and the Scheduled Fee for the Covered Expense. Use of an Out-of-Network Provider may result in additional charges. Out-of-Network Providers may bill you for the difference between the Allowance shown below and the Provider's actual charge for the eye examination and materials.

A. FREQUENCY OF USE

Eye Examination	Once every 12 months.
Materials	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every [12 or 24] months and frame every [12 or 24] months.

B. IN-NETWORK BENEFITS

Eye Examination	Co-payment * [0 to \$25.00]
Materials	
Eyeglasses (lenses and frames)	[0 to \$25.00]
Contact Lenses	
Soft Standard Daily Wear	[0 to \$25.00]
Disposable / Planned Replacement (Initial Supply)	[0 to \$25.00]
Medically Necessary Contact Lens - (Keratoconus)	[0 to \$25.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will be paid at the same level as for non-Medically Necessary Contact Lenses.

- * Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.
- ** Frames other than Davis Vision's Fashion, Designer or Premier Collections will be paid up to a maximum of \$60.00. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Designer or Premium Collection there is an additional copayment; see "Optional In-Network Items" below.
- *** Contact lenses other than Standard, Soft, Daily Wear or Disposable / Planned Replacement contact lenses will be paid up to a maximum of \$50.00. The balance, if any is the Covered Person's responsibility.

Plan Level

Fashion Plan Eyewear from Davis Vision's Fashion Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Designer or Premier Collection. All Optional In-Network Items are subject to the applicable Copayment.

<u>Optional In-Network Items</u>	<u>Copayment</u>
Designer Frames	\$15.00
Premier Frames	\$40.00
Glass Grey #3 prescription lenses	\$11.00
Fashion, sun and gradient tinted plastic lenses	\$11.00
Scratch Resistant Coating	\$20.00
Ultra Violet Coating	\$12.00
Anti-Reflective Coating	
Standard Types	\$35.00
Premium Types	\$48.00
Progressive Addition Multifocal Lenses	
Standard Types	\$50.00
Premium Types	\$90.00
Intermediate Vision Lenses	\$30.00
Blended Segment Lenses	\$20.00
Polycarbonate Lenses	\$30.00*
High index lenses	\$55.00
Polarized lenses	\$75.00
Photogrey Extra (photosensitive) glass lenses	\$20.00
Plastic Photosensitive lenses	\$65.00

* no copayment for children up to age 19 or monocular patients.

C. OUT-OF-NETWORK BENEFITS

A Covered Person may use the Provider of their choice for the following covered vision services. Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

Eye Examination	Allowance *
Materials:	[\$40.00]
Frames	[\$45.00]
Lenses:	
Single Vision	[\$40.00]
Bifocal	[\$60.00]
Trifocal	[\$80.00]
Lenticular	[\$80.00]
Contact Lenses	[\$105.00]

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are the Covered Person's responsibility.

Medically Necessary Contact Lens - (Keratoconus) [\\$225.00]

Note this benefit is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for the correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will be paid at the same level for non-Medically Necessary Contact Lenses.

D. LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)
Maximum per Evaluation	\$300.00
Maximum per Follow-up Visit	\$100.00
Low Vision Aids	
Maximum per Aid	\$600.00
Lifetime Maximum for all Aids	\$1,200.00

Note this program is available both in and out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be the Covered Person's responsibility.

Part 4. COVERED EXPENSES

Subject to the exclusions and limitations in Part 5, Covered Expenses include charges made by a Provider for the following vision care services while the you or your Dependents, if any, are insured for these benefits. The benefits payable under the Group Policy vary depending upon which Provider rendered the services.

A. EYE EXAMINATION

Covered Expenses for an eye examination include the following procedures:

1. Case history - chief complaint, eye and vision history, medical history
2. Entrance distance acuities
3. External ocular evaluation including slit lamp examination
4. Internal ocular examination
5. Tonometry
6. Distance refraction - objective and subjective
7. Binocular coordination and ocular motility evaluation
8. Evaluation of pupillary function
9. Biomicroscopy
10. Gross visual fields
11. Assessment and plan
12. Advise a Covered Person on matters pertaining to vision care.
13. Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in Part 3. Benefits under the Group Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in Part 3 or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

B. FITTING OF EYEGLASSES

If vision correction is recommended by a Provider, Covered Expenses will include the fitting of eyeglasses and follow-up adjustments.

C. MATERIALS

Fashion Collection frames and the following lenses as provided through Davis Vision:

1. Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:

- a. Oversized lenses
- b. Cataract lenses
- c. Contact lenses

The above materials are subject to the Copayment for In-Network Benefits shown in Part 3.

2. Optional In-Network Items. Charges for the following items. These materials are subject to the Copayment for Optional In-Network Items shown in Part 3:

- a. Glass Grey #3 prescription lenses
- b. Fashion, sun and gradient tinted plastic lenses
- c. Progressive addition lenses
- d. Photogrey Extra (photosensitive) glass lenses
- e. Scratch Resistant Coating
- f. ARC (Anti-Reflective Coating)
- g. Blended Segment Bifocal Lenses
- h. Ultraviolet Coating
- i. Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals)
- j. High index lenses
- k. Plastic Photosensitive Lenses
- l. Polarized lenses
- m. Intermediate Vision Lenses
- n. Premier Frames
- o. Designer Frames

Frames and lenses from an Out-of-Network Provider or from an In-Network Providers own collection are payable up to the Allowance shown in Part 3 for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in Part 3. Schedule of Benefits.

Medically necessary contact lenses prescribed for a Covered Person affected with Keratoconus are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be your responsibility.

D. LOW VISION PROGRAM

Benefits are payable up to the allowance, subject to the maximum shown in Part 3 for the Covered Expense.

Covered Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation.
- Follow-up visits.
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be your responsibility.

Part 5. EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For services or supplies not recommended by a Provider.
2. For periodic vision examinations, except as provided for in Part 3.
3. For eye examinations required by a Employer as a condition of employment.
4. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
5. For lenses which do not provide vision correction.
6. For charges for the replacement of lost or stolen lenses or frames within 24 months of service.
7. For sickness or injury covered by a workers' compensation act or other similar legislation.
8. Incurred as a direct or indirect result of war (declared or undeclared).
9. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
10. For services or supplies furnished to a Covered Person before the effective date of the Group Policy or after the date a Covered Person's Insurance ends.
11. For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
12. For any medical treatment rendered outside the United States.
13. For services rendered by practitioners who do not meet the definition of Provider.
14. For expenses covered by:
 - a. Any other group insurance.
 - b. A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.
15. For any expenses covered by any union welfare plan or governmental program or a plan required by law.
16. For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

Part 6. OTHER VISION CARE INSURANCE PROVISIONS

A. FREE CHOICE OF PROVIDER

You have the exclusive right to select the Provider of your choice to provide you with vision care services and materials. We are not responsible for the quality of care you receive from the Provider you select. We cannot be held liable for any injuries you suffer while receiving the vision services or materials.

B. INCURRED DATE

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1. The date a service or procedure is performed; or
2. The date a purchase is made.

C. COORDINATION OF BENEFITS PROVISION

1. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 4, "Effect on the Benefits of This Plan."

2. Definitions

- a. "Plan" means any of the following which provides benefits or services for, or because of, medical or vision care or treatment:
- (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
 - (3) "Plan" does not include school accident-type coverage, individual contracts of coverage, some supplemental sickness and accident policies, or the medical benefits coverage in a group, group-type, and individual motor vehicle "nofault" and traditional automobile "fault" type contracts. Each contract or other arrangement for coverage under (1) or (2) is a separate plan.

If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

- b. "This Plan" is the part of the Group Policy that provides benefits for vision care expenses.
- c. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.
- d. "Allowable Expense" means a necessary, reasonable and customary item of expense for vision care when the item of expense is covered by This Plan. However, This Plan is not required to pay for a service, supply, or treatment which is not covered by the Group Policy. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and benefit paid.
- e. "Benefit reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.
- f. "Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each plan will pay or provide
- g. "Complying plan" means a plan with benefit determination requirements that comply with the requirements of the jurisdiction where the policy was issued.
- h. "Coordination of benefits" means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

- i. “Non-complying plan” means a plan with no benefit determination requirements or whose benefit determination requirements do not comply with the requirements of the jurisdiction in which the policy was issued.

3. Order of Benefit Determination Rules

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan whose benefits are determined after those of the other plan, unless:

- (1) the other plan has rules coordinating its benefits with those of This Plan; and
- (2) both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other plan.

- b. This Plan determines its order of benefits using the first of the following rules which applies:

- (1) The benefits of the plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (a) secondary to the plan covering the person as a Dependent; and
- (b) primary to the plan covering the person as other than a Dependent (e.g. a retired employee).

- (2) Benefits for a Dependent child whose parents are not separated or divorced will be determined as follows:

- (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
- (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which has covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (3) Benefits for a Dependent child whose parents are divorced or separated will be determined as follows. To the extent the plan has been notified by receiving a copy of the court decree:

- (a) If the specific terms of the court decree state that one of the parents is responsible for the vision care expenses of the child, the benefits of the plan of that parent are determined first. The plan of the other parent will be the Secondary Plan.
- (b) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the vision care expenses of the child, the plans covering the child will be subject to the order of benefit determination contained in subdivision (B)(2) of this section.

If neither subdivision (a) nor (b) applies, the order of benefits will be determined in the following order:

- (i) the plan of the parent with custody of the child;
- (ii) the plan of the spouse of the parent with the custody of the child;
- (iii) the plan of the parent not having custody of the child; and
- (iv) the plan of the spouse of the parent not having custody of the child.

- (4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before the benefits of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another plan, the benefits of the plan covering the person as employee, member or subscriber (or that person's Dependent) will be determined before the benefits under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph will be ignored.
- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

- a. This section applies when, in accordance with 3, "Order of Benefit Determines Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. The other plan or plans are referred to as "the other plans" in "b" below.
- b. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
 - (1) The benefits that would be payable for the allowable expense under This Plan in the absence of this COB provision; and
 - (2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this except as required by law in which this certificate is issued. Each person claiming benefits under This Plan must give us any facts we need to pay the claim. Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

- a. the persons it has paid or for whom it has paid;
- b. another plan; or
- c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

D. CONFORMITY WITH STATE STATUTES

If any provision of the Policy is in conflict with the statutes of the state in which the Policy is delivered or issued for delivery, the provision is automatically amended to meet the minimum requirements of such statutes.

Part 7. WHEN A MEMBER'S INSURANCE ENDS

Your Insurance under the Group Policy will end automatically on the earliest of the following dates:

1. The date you cease to be a Member as defined in Part 1A, your benefits will end at the end of that month.
2. The date you become a full time member of the armed forces of any country.
3. The date the Group Policy terminates.
4. On the last day of the last period for which you make the required contribution for your Insurance.

Part 8. WHEN A DEPENDENT'S INSURANCE ENDS

Insurance on your Dependents will end automatically on the earliest of the following dates:

1. The date your Insurance ends for any reason.
2. The date the person ceases to be your Dependent, as defined in Part 2A.
3. The date your Dependent becomes a full time member of the armed forces of any country.
4. On the last day of the last period for which you made the required contribution for Insurance on your Dependents.

Continued Coverage For A Handicapped Child:

Insurance on a Dependent child will not end solely because the child ceases to be a Dependent as defined in Part 2 if you provide us with satisfactory written proof that the child qualifies for continued coverage as a Handicapped Child. This proof must be furnished to us on our forms within 31 days after the child ceases to be a Dependent as defined, and thereafter as required by us, but not more often than once a year after the two year period following the child's attainment of the limiting age. We have the right, at our expense, to have your child examined at reasonable intervals while you are claiming continued coverage under this provision.

Insurance on a Handicapped Child will end automatically on the earliest of the following dates:

1. The date the child becomes capable of self-sustaining employment.
2. The date the child ceases to be chiefly dependent upon you for support and maintenance.
3. 90 days after the date we mail you a request for proof that the child continues to qualify as a Handicapped Child, unless you provide us with the required proof within that 90 day period.
4. The date the Handicapped Child marries.
5. The date coverage would end under this Part 8 for any reason other than the child's attainment of the limiting age.

Part 9. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You and your Dependents, if any, may become insured again under the Group Policy after Insurance ends. The general rule is that you and your Dependents, if any, may become insured again on the same basis as a new Member, as provided in Parts 1 and 2. However, for purposes of becoming insured again, the following rules will apply:

1. If Insurance ends because you cease to be a Member, you and your Dependents, if any, will be immediately eligible for Insurance if you become a Member again within 90 days after your Insurance ends. If you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible for Insurance again the person or persons applying for Insurance will not be eligible until the next Open Enrollment Period, if applicable.
2. If your Insurance ends because you become a full time member of the armed forces of the United States, you will not be required to satisfy any eligibility waiting period shown in Part 1B again.
3. If Insurance ends because you fail to make the required premium contribution, you and your Dependents, if any, will not be eligible until the next Open Enrollment Period, if applicable.
4. If you did not apply for Insurance within 31 days after becoming eligible again and experience a Life Event, you and your Dependents, if any, will be immediately eligible for Insurance. However, if you do not apply for your Insurance or Insurance on your Dependents, if any, within 31 days after becoming eligible again due to a change in family status you may not apply until the next Open Enrollment Period, if applicable.

Insurance which becomes effective again will not be retroactive to the date the Insurance ended.

Part 10. PAYMENT OF CLAIMS

A. PAPERLESS SYSTEM

The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Davis Vision before the examination takes place. The Provider will submit Covered Person's claim directly to Davis Vision.

B. PAYMENT OF BENEFITS

All in-network benefits will be paid directly to the Provider. Out-of-network benefits will be paid to you unless you provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of your death will either be paid to your beneficiary or to your estate. If any benefits are payable to your estate, or to a person who is a minor, or otherwise not competent to give a valid release, we may pay the indemnity to an amount not exceeding \$1,000 to any of your relatives by blood or marriage who we deem to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment.

C. NOTICE OF CLAIM

Written notice of a claim must be given to Davis Vision within 60 days after the incurred date of the Covered Expense or as soon thereafter as reasonable possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. If an In-Network Provider is used, notice of claim will be given to Davis Vision directly by the Provider on behalf of the Covered Person.

D. CLAIM FORMS

All claims for benefits should be submitted on our forms. All claims for out-of-network benefits should be submitted on our forms. You or the Provider should obtain claim forms from the Policyholder, Citizens Security Life Insurance Company or Davis Vision. If we fail to provide you with claim forms within 15 days of your request, you:

1. May submit your claim in a letter stating the medical expense for which the claim is made.
2. Will be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

E. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to us at your expense. No benefits for such charges will be paid until we receive satisfactory written proof:

1. That a Covered Person has incurred a Covered Expense.
2. That the charges for which benefits are claimed are not subject to any exclusion.
3. That a Covered Person's Insurance under the Group Policy was in effect on the date the charge was incurred.
4. Of such additional information as we reasonably require in connection with the claim for benefits.

You must provide your written authorization for us to obtain the records and information needed to evaluate your eligibility for benefits. Such proof must be given to us within 90 days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible.

Failure to provide written proof of a loss within the 12 month period will not invalidate or reduce a claim if:

- a. it was not reasonably possible to provide written proof of the loss within that time; or
- b. written proof of the loss is provided as soon as reasonably possible.

Claims not filed within these time limits will be denied and no benefits will be paid. These time limits will not apply during any period when a Covered Person lacked the legal capacity to file a claim.

Any claim for benefits submitted by an In-Network Provider through the Paperless System (see A, PAPERLESS SYSTEM) will satisfy this requirement.

F. TIME PAYMENT OF CLAIMS

Subject to satisfactory written proof of loss, any benefits payable under the Group Policy will be paid within 30 days of our written receipt of such proof of loss, or our initial notice of decision of claim, if later.

G. INDEPENDENT EXAMINATION

We have the right to have a Provider of our choice examine you or your covered insured Dependent to evaluate and confirm the services and supplies for which benefits are claimed. Any such examination will be conducted at our expense. We have the right to defer payment of benefits if the Provider or you or your covered insured Dependent fail to permit or cooperate with a review by the Provider of our choice.

H. RIGHT TO RECOVER BENEFITS PAID BY MISTAKE

If we mistakenly make a payment to you or to a Provider on your behalf for benefits, and you are not eligible for all or a part of that payment, then we have the right to recover the payment from you or the Provider who received the payment. Our right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

I. CHILD SUPPORT PAYMENTS

We will not refuse to accept and honor an otherwise valid claim for benefits which is filed by either parent of a covered child, by the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order. If we cover the child of a noncustodial parent or a parent sharing custody or temporary control of the child we will:

1. Provide such information to either the parent sharing custody, or temporary control, of the child as may be necessary for the child to obtain benefits;
2. Permit either the parent sharing custody, or temporary control, of the child, or the Provider with either parent's approval, to submit claims for Covered Expenses without the approval of the other parent; and
3. Make payments on claims directly to the parent who paid for the services, the Provider, the state agency or department responsible for administering the order, or other agency appointed by a court of competent jurisdiction pursuant to a qualified medical child support order.

J. ASSIGNMENT

No assignment of interest under the Group Policy will be binding upon us unless and until the original or a duplicate is received at our home office, or by our authorized representative. We do not assume any responsibility for the validity of an assignment.

K. LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part 11. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your Insurance would not have been approved if the truth had been known.
2. Your misrepresentation is contained in a written instrument signed by you.
3. You or your beneficiary have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for three years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance unless it was a fraudulent misrepresentation made with actual intent to deceive. However, we have the right at any time to assert as a defense to a claim that you were not eligible to become insured because you did not meet the requirements of Part 1, including, but not limited to, the requirements that you (1) be a Member and (2) submit and have approved an Enrollment Form.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if the truth had been known.
2. The misrepresentation is contained in a written instrument signed by the Policyholder.
3. A copy of the written instrument has been given to the Policyholder.

The validity of the Group Policy will not be contested after it has been in effect for three years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 12. CLERICAL ERROR

Clerical error by the Policyholder will not:

1. Cause you to become insured.
2. Invalidate Insurance otherwise validly in force.
3. Continue Insurance otherwise validly terminated.

Part 13. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we will administer claims and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. Our authority includes, but is not limited to, the following:

1. The right to resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it.
3. The right to determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

Part 14. GENERAL DEFINITIONS

ALTERNATE RECIPIENT This term means any child of a participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Group Policy as the participant's eligible Dependent. For purposes of the benefits provided under the Group Policy, an Alternate Recipient will be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient will have the same status as a participant.

ALLOWANCE The flat dollar amount payable under the Group Policy for eye examinations, the fitting of eyeglasses or Materials received and/or purchased by a Covered Person.

APPLICATION The written request of a duly authorized representative for Insurance under the Group Policy on a form acceptable to us.

CALENDAR YEAR The twelve month period beginning on January 1st and ending on December 31st.

CLAIM This term means a request that benefits of a plan be provided or paid, and the benefits claimed may be in the form of: (a) Services including supplies; (b) Payment for all or a portion of the expenses incurred; (c) a combination of (a) and (b); or (d) An indemnification.

COPAYMENT The amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in Part 3. Schedule of Benefits.

COVERED DEPENDENT A Member's Dependent insured under the Group Policy.

COVERED EXPENSE An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by a Covered Person, for which benefits are payable under the Group Policy.

COVERED PERSON means a Member insured under the Group Policy or a Member's Dependent insured under the Group Policy.

CUSTODIAL PARENT The term means the parent awarded custody of a child by a court decree, or with whom the child resides more than one-half (1/2) of the calendar year.

EFFECTIVE DATE The date shown on the cover page. This is the date on which the Group Policy becomes effective.

ENROLLMENT, ENROLLMENT FORM The written request for enrollment in the plan of Insurance by an eligible person on a form acceptable to us.

GROUP means the Policyholder to which the Policy is issued.

GROUP POLICY means our group policy number issued to the Policyholder.

HANDICAPPED CHILD means your unmarried child who, on and after the date the child ceases to be a Dependent, is both: (1) continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a Dependent; and (2) continuously chiefly dependent upon you for support and maintenance. Your child will be considered chiefly dependent upon you for support and maintenance during any period when your child is institutionalized because of mental retardation or physical handicap.

INDIVIDUAL CERTIFICATE means a certificate that states the insurance protection to which an Insured Person is entitled and to whom the benefits are payable. We will make a certificate available to the Insured Member.

IN-NETWORK PROVIDER Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

INSURANCE The group vision care insurance provided to you and your Dependents, if any, under the Group Policy.

INSURANCE CONTRACT The term means a policy contract issued by a qualified insurer.

INSURED MEMBER means the Group Member who has insurance coverage under this Policy.

LIFE EVENT One of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your child; (4) the death of your child; (5) a change in the employment status of your spouse.

MATERIALS Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Group Policy.

MEDICAL CHILD SUPPORT ORDER This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act Sect. 1908 (as added by Omnibus Budget Reconciliation Act of 1993 sect. 13822) with respect to a group health plan.

MEMBER means a person who is enrolled and part of a business, professional or trade Group.

OPEN ENROLLMENT PERIOD The period of time, established by the Policyholder, during which you have an opportunity to select your benefits and your Dependent's benefits for the coming year.

OPTIONAL IN-NETWORK ITEMS Materials provided under the Group Policy that can be selected at the Covered Person's option, subject to a Copayment, if any, shown in Part 3. Schedule of Benefits.

OUT-OF-NETWORK PROVIDER Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

POLICYHOLDER The legal entity to whom the Group Policy is issued.

PROVIDER A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the State in which the services are provided. The Group Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER This term means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or eligible Dependent is entitled under the Group Policy. In order for such an order to be a QMCSO, it must clearly specify:

1. the name and last known mailing address (if any) of the participant and the name and mailing address of each the Alternate Recipient covered by the order;
2. a reasonable description of the type of coverage to be provided under the Group Policy to each Alternate Recipient, or the manner in which that type of coverage is to be determined;
3. the period of coverage to which the order applies; and
4. each plan to which the order applies.

RIDER/ENDORSEMENT A formal document, signed by one of our authorized officers and attached to the Group Policy or a Certificate of Insurance issued under the Group Policy, that amends the Group Policy to provide additional benefits, or to remove exclusions and/or limitations.

SCHEDULED FEE The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by a Covered Person.

USUAL AND CUSTOMARY CHARGE That portion of a charge, as determined by us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

VOLUNTARY means you elect and pay the entire cost of your Insurance. The Insurance on your Dependents is Voluntary if you elect and pay the entire cost of your Dependent's Insurance. You must enroll for both your and your Dependents Insurance.

WE, US, OUR OR THE COMPANY With respect to group vision insurance benefits, the insurance company identified on the cover page.



May 13, 2009

Arkansas Department of Insurance
Health Division, Forms and Rates
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: Citizens Security Life Insurance Company - **New Submission**
NAIC#-61921 FEIN# 61-0648389
Form # ASLU MAST GPA 02 09 AR; Group Vision Master Policy
ASLU CERT GPA 02 09 AR; Group Vision Certificate

Dear Sir/Madam:

Enclosed please find our group vision product for your review and approval. These are new policy forms and will not replace any existing forms.

Our group products are marketed by brokers and independent agents. This vision product will be a companion product to our group life and group dental products which are being filed concurrently with this filing, but under a separate SERFF number.

These forms will be marketed to Associations and Labor Unions on a voluntary basis.

The applications that will be used with this vision product are form # ASLU APP GLA 01 09 AR and form # ASLU ENR GLA 01 09 AR, which are being filed with the group life product.

A Statement of Variability is attached to the Master Policy and Certificate.

If you should have any questions concerning this filing, please contact me at (800) 843-7752 or e-mail rbolduc@cslico.com. Your prompt attention to this filing is greatly appreciated.

Sincerely,

A handwritten signature in black ink that reads 'Rickie Ellen Bolduc'.

Mrs. Rickie Ellen Bolduc, FLMI, AIRC, ACS
Actuarial Associate