

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Premier Choice - Vision SERFF Tr Num: SLIA-127064669 State: Arkansas
TOI: H20G Group Health - Vision SERFF Status: Closed-Approved- State Tr Num: 48166
Closed

Sub-TOI: H20G.000 Health - Vision Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Stacy Patacsil Disposition Date: 03/09/2011
Date Submitted: 03/04/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 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
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 03/09/2011
State Status Changed: 03/09/2011 Deemer Date:
Created By: Stacy Patacsil Submitted By: Stacy Patacsil
Corresponding Filing Tracking Number:

Filing Description:

The following forms are being submitted for your review and approval.

ELHERAPPVIS2-9.2010 – Vision Insurance 2 to 9 Product Addendum
ELHERAPPVIS.2010 – Vision Insurance 10+ Product Addendum
ELHERAPPVIS.2010 - Voluntary Dental Insurance Product Addendum

GP2010VSB - Vision Schedule of Benefits

GP2010VBP - Vision Benefit Provisions

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

GP2010VVSB - Voluntary Vision Schedule of Benefits
GP2010VVBP - Voluntary Vision Benefit Provisions

The Application consists of:

- Group Application (ERAPP.2010 – pending approval - SLIA-127053875)
- Applicable Addenda
- Enrollment forms for all eligible employees enrolling for coverage (GB207.2010 – pending approval - SLIA-127053875)
- Evidence of Insurability Form, when applicable (GB215.2010 – pending approval - SLIA-127053875)

The Policy issued to the employer will include:

- Application
- Employer Acceptance Application (GP2010APP-AR - pending approval - SLIA-127053875)
- Master Policy (GP2010MP – pending approval - SLIA-127053875)
- Master Certificate (GP2010MC – pending approval - SLIA-127053875)
- Summary of Benefits and Benefit Provisions for each applicable coverage

Certificates issued to employees are comprised:

- Master Certificate
- Summary of Benefits and Benefit Provisions for each applicable coverage

The enclosed group forms provide employer-employee group insurance coverage through policies issued to employers in your state. Policies are sold by licensed agents and brokers to groups.

The coverage provided includes Vision benefits on a voluntary and non-voluntary basis.

We will be delegating the PPO responsibilities to Vision Service Plan Insurance Company (VSP), who, in turn, will be acting as a third party administrator for Vision Insurance plans issued by Security Life Insurance Company of America.

Please note that the Schedule of Benefits and any bracketed text is intended to be variable and is customized for each group policyholder.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Stacy Patacsil,
25 Race Ave

spatacsil@securitylife.com
888-654-7100 [Phone] 5718 [Ext]

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /
 Lancaster, PA 17608

Filing Company Information

Security Life Insurance Company of America	CoCode: 68721	State of Domicile: Minnesota
10901 Red Circle Drive	Group Code: 492	Company Type: Life, Accident & Health
Minnetonka, MN 55343-9137	Group Name:	State ID Number:
(952) 544-2121 ext. 3589[Phone]	FEIN Number: 41-0808596	

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? Yes
 Fee Explanation: MN filing fee
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$250.00	03/04/2011	45273644
Security Life Insurance Company of America	\$100.00	03/04/2011	45281303

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/09/2011	03/09/2011

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	03/07/2011	03/07/2011	Stacy Patacsil	03/09/2011	03/09/2011
Pending Industry Response	Rosalind Minor	03/04/2011	03/04/2011	Stacy Patacsil	03/04/2011	03/04/2011

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

Disposition

Disposition Date: 03/09/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Vision Addendum	Approved-Closed	Yes
Form	Vision 2-9 Addendum	Approved-Closed	Yes
Form	Voluntary Vision Addendum	Approved-Closed	Yes
Form	Vision Schedule of Benefits	Approved-Closed	Yes
Form (revised)	Vision Benefit Provisions	Approved-Closed	Yes
Form	Vision Benefit Provisions	Replaced	Yes
Form	Voluntary Vision Schedule of Benefits	Approved-Closed	Yes
Form (revised)	Voluntary Vision Benefit Provisions	Approved-Closed	Yes
Form	Voluntary Vision Benefit Provisions	Replaced	Yes

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 03/07/2011

Submitted Date 03/07/2011

Respond By Date

Dear Stacy Patacsil,

This will acknowledge receipt of the captioned filing.

Objection 1

- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Benefit Provisions, GP2010VVBP (Form)

Comment:

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

Objection 2

- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Benefit Provisions, GP2010VVBP (Form)

Comment:

Coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to the 60-day period under ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 03/09/2011
 Submitted Date 03/09/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: The time limit set for furnishing proof of incapacity has been deleted.

Related Objection 1

Applies To:

- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Benefit Provisions, GP2010VVBP (Form)

Comment:

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

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Vision Benefit Provisions	GP2010V BP-AR		Certificate	Initial		0.000	GP2010V BP-AR.pdf
Previous Version							
Vision Benefit Provisions	GP2010V BP		Certificate	Initial		0.000	GP2010V BP.pdf
Voluntary Vision Benefit	GP2010V		Certificate	Initial		0.000	GP2010V

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /
 Provisions VBP-AR VBP-AR.pdf

Previous Version

Voluntary Vision Benefit GP2010V Certificate Initial 0.000 GP2010V
 Provisions VBP VBP.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: The definition of Child has been revised to include the required language for adopted child. Additionally, language concerning adopted children has been added to the Effective Date of your Dependent Vision Coverage.

Related Objection 1

Applies To:

- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Benefit Provisions, GP2010VVBP (Form)

Comment:

Coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to the 60-day period under ACA 23-79-137.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Vision Benefit Provisions	GP2010V BP-AR		Certificate	Initial		0.000	GP2010V BP-AR.pdf
Previous Version							
Vision Benefit Provisions	GP2010V BP		Certificate	Initial		0.000	GP2010V BP.pdf
Voluntary Vision Benefit Provisions	GP2010V VBP-AR		Certificate	Initial		0.000	GP2010V VBP-

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

AR.pdf

Previous Version

Voluntary Vision Benefit	GP2010V	Certificate	Initial	0.000	GP2010V
Provisions	VBP				VBP.pdf

No Rate/Rule Schedule items changed.

Additionally, Coverage for newborn children has been increased to 90 days. Because of the state specific changes, the form numbers have been revised.

Sincerely,
Stacy Patacsil

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/04/2011
Submitted Date 03/04/2011
Respond By Date 04/04/2011

Dear Stacy Patacsil,

This will acknowledge receipt of the captioned filing.

Objection 1

- Vision Addendum, ELHERAPPVIS.2010 (Form)
- Vision 2-9 Addendum, ELHERAPPVIS2-9.2010 (Form)
- Voluntary Vision Addendum, ELHERAPPVVIS.2010 (Form)
- Vision Schedule of Benefits, GP2010VSB (Form)
- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Schedule of Benefits, GP2010VVSB (Form)
- Voluntary Vision Benefit Provisions, GP2010VVBP (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$350.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

SERFF Tracking Number: SLIA-127064669 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
Company Tracking Number:
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/04/2011
Submitted Date 03/04/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: The additional fee has been submitted.

Related Objection 1

Applies To:

- Vision Addendum, ELHERAPPVIS.2010 (Form)
- Vision 2-9 Addendum, ELHERAPPVIS2-9.2010 (Form)
- Voluntary Vision Addendum, ELHERAPPVVIS.2010 (Form)
- Vision Schedule of Benefits, GP2010VSB (Form)
- Vision Benefit Provisions, GP2010VBP (Form)
- Voluntary Vision Schedule of Benefits, GP2010VVS (Form)
- Voluntary Vision Benefit Provisions, GP2010VVB (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$350.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number: SLIA-127064669 *State:* Arkansas
Filing Company: Security Life Insurance Company of America *State Tracking Number:* 48166
Company Tracking Number:
TOI: H20G Group Health - Vision *Sub-TOI:* H20G.000 Health - Vision
Product Name: Premier Choice - Vision
Project Name/Number: /

No Rate/Rule Schedule items changed.

Sincerely,
Stacy Patacsil

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/09/2011	ELHERAP PVIS.2010	Application/Vision Addendum Enrollment Form		Initial		0.000	ELHERAPPVIS.2010.pdf
Approved-Closed 03/09/2011	ELHERAP PVIS2-9.2010	Application/Vision 2-9 Addendum Enrollment Form		Initial		0.000	ELHERAPPVIS2-9.2010.pdf
Approved-Closed 03/09/2011	ELHERAP PVIS.2010	Application/Voluntary Vision Enrollment Addendum Form		Initial		0.000	ELHERAPPVIS.2010.pdf
Approved-Closed 03/09/2011	GP2010VS B	Schedule Pages	Vision Schedule of Benefits	Initial		0.000	GP2010VSB.pdf
Approved-Closed 03/09/2011	GP2010VB P-AR	Certificate	Vision Benefit Provisions	Initial		0.000	GP2010VBP-AR.pdf
Approved-Closed 03/09/2011	GP2010VV SB	Schedule Pages	Voluntary Vision Schedule of Benefits	Initial		0.000	GP2010VVSB.pdf
Approved-Closed 03/09/2011	GP2010VV BP-AR	Certificate	Voluntary Vision Benefit Provisions	Initial		0.000	GP2010VVBP-AR.pdf

**Security Life Insurance Company of America
Vision Insurance 10+ Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Vision Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	Current Carrier:
Number of COBRA Employees Enrolling: _____ <small>(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)</small>	
Does your plan require an Annual Open Enrollment? <input type="checkbox"/> No <input type="checkbox"/> Yes Annual open enrollment will occur during the month preceding the renewal date.	
Termination of Coverage will occur on: <input type="checkbox"/> the date the employee is no longer actively at work <input type="checkbox"/> the end of the month in which the employee is no longer actively at work	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility:
Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: _____% for employee coverage	
Dependent Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: _____% for dependent coverage	
Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	

Plan Information	
Member Vision Provider Copayment*:	
<input type="checkbox"/> \$5 Exam/\$5 Materials	<input type="checkbox"/> \$5 Exam/\$10 Materials
<input type="checkbox"/> \$10 Exam/\$20 Materials	<input type="checkbox"/> \$15 Exam/\$25 Materials
<input type="checkbox"/> \$10 Exam & Materials	<input type="checkbox"/> \$10 Exam/\$10 Materials
<input type="checkbox"/> Other \$_____ Exam \$_____ Materials	
<small>*Benefit for services rendered by a non-member vision provider is based on a reimbursement schedule</small>	
Frequency (Exam/Lenses/Frame):	Frequency (Exam/Lenses/Frame) for covered dependent children, under age 19, if different:
<input type="checkbox"/> 12 Months/12 Months/12 Months	<input type="checkbox"/> 12 Months/12 Months/12 Months
<input type="checkbox"/> 12 Months/12 Months/24 Months	<input type="checkbox"/> 12 Months/12 Months/24 Months
<input type="checkbox"/> 12 Months/24 Months/24 Months	<input type="checkbox"/> 12 Months/24 Months/24 Months
<input type="checkbox"/> 24 Months/24 Months/24 Months	<input type="checkbox"/> 24 Months/24 Months/24 Months

Vision Insurance 10+ Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Vision Insurance 2 to 9 Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

**Security Life Insurance Company of America
Voluntary Vision Insurance Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Vision Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	Current Carrier:
Number of COBRA Employees Enrolling: _____ <small>(Each COBRA employee must complete an Employee Enrollment Form and indicate the COBRA start date and qualifying event.)</small>	
Open Enrollment Date: Annual open enrollment will occur during the month preceding the renewal date.	
Termination of Coverage will occur on: <input type="checkbox"/> the date the employee is no longer actively at work <input type="checkbox"/> the end of the month in which the employee is no longer actively at work	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility:
Dependent Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	

Plan Information	
Member Vision Provider Copayment*:	
<input type="checkbox"/> \$5 Exam/\$5 Materials	<input type="checkbox"/> \$5 Exam/\$10 Materials
<input type="checkbox"/> \$10 Exam/\$20 Materials	<input type="checkbox"/> \$15 Exam/\$25 Materials
<input type="checkbox"/> \$10 Exam & Materials	<input type="checkbox"/> \$10 Exam/\$10 Materials
<input type="checkbox"/> Other \$_____ Exam \$_____ Materials	<input type="checkbox"/> \$5 Exam & Materials
<small>*Benefit for services rendered by a non-member vision provider is based on a reimbursement schedule</small>	
Frequency (Exam/Lenses/Frame):	Frequency (Exam/Lenses/Frame) for covered dependent children, under age 19, if different:
<input type="checkbox"/> 12 Months/12 Months/12 Months	<input type="checkbox"/> 12 Months/12 Months/12 Months
<input type="checkbox"/> 12 Months/12 Months/24 Months	<input type="checkbox"/> 12 Months/12 Months/24 Months
<input type="checkbox"/> 12 Months/24 Months/24 Months	<input type="checkbox"/> 12 Months/24 Months/24 Months
<input type="checkbox"/> 24 Months/24 Months/24 Months	<input type="checkbox"/> 24 Months/24 Months/24 Months

Voluntary Vision Insurance Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Vision Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[Not Available][October 1 – October 31]
[Work Hours Required for Eligibility]	Your regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	<p>For your coverage: [90] [days] [months] [For your dependent coverage: [90] [days] [months]]</p> <p>[Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.]</p> <p>[There will be no waiting period for employees who are actively at work and are part of the initial enrollment.]</p>
Your Premium Contribution	You are [not] required to contribute towards the cost of your coverage . [You are [not] required to contribute towards the cost of your dependent coverage .]
Frequency	<p>[Covered Dependent Children, under age 19:</p> <p>Eye Examination: One visit every [12] months Eyeglass Lenses: One pair every [12] months Frames: One frame every [12] months Elective Contact Lenses: One pair every [12] months in lieu of eyeglass lenses and frame]</p> <p>[You and your covered dependents, age 19 and over:]</p> <p>Eye Examination: One visit every [12] months Eyeglass Lenses: One pair every [12] months Frames: One frame every [12] months</p>

Vision Insurance

Schedule of Benefits

Elective Contact Lenses: One pair every [12] months in lieu of eyeglass lenses and frame

Vision Benefit

	Member Vision Provider	Non-Member Vision Provider
[Eye Examination:	100% after \$[15] copay	[\$45], \$[15] copay applies
Eyeglass Lenses:		
Single Vision	100% after \$[25] material copay	[\$45], \$[25] material copay applies
Bifocal	100% after \$[25] material copay	[\$65], \$[25] material copay applies
Trifocal	100% after \$[25] material copay	[\$85], \$[25] material copay applies
Lenticular	100% after \$[25] material copay	[\$85], \$[25] material copay applies
Frame:	[\$120] after \$[25] material copay	[\$47], \$[25] material copay applies

[\$25] material copay amount is combined for Eyeglass Lenses and Frame.]

[Eye Examination:	100% after \$[25] combined copay	[\$45], \$[25] combined copay applies
Eyeglass Lenses:		
Single Vision	100% after \$[25] combined copay	[\$45], \$[25] combined copay applies
Bifocal	100% after \$[25] combined copay	[\$65], \$[25] combined copay applies
Trifocal	100% after \$[25] combined copay	[\$85], \$[25] combined copay applies
Lenticular	100% after \$[25] combined copay	[\$85], \$[25] combined copay applies
Frame:	[\$120] after \$[25] combined copay	[\$47], \$[25] combined copay applies

[\$25] copay amount applies to the Eye Examination, Eyeglass Lenses, or

Vision Insurance

Schedule of Benefits

Frame, whichever is received first.]

Elective Contact Lenses (in lieu of eyeglass lenses and frame):

[\$120]

[\$105]

Low Vision Services

Low Vision Supplemental Testing:

**Member
Vision Provider**
Covered in full

**Non-Member
Vision Provider**
up to \$[125] every [2] years

Low Vision Aids:

[75]% up to \$[1,000] every [2] years, less any amount paid for supplemental testing

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence

[Temporary Layoff – [Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.] [Up to [3] months after **your** last day of **active work**.]]

Injury or Illness – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

[Dependent Vision Coverage

[Not] Included]

[Dependent Student Age Limit

[23 years]]

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage**.]

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];
3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
 - a. a full-time student at an accredited school;
 - b. primarily dependent upon **you** for support and maintenance;
 - c. not married; and
 - d. under the Dependent Student Age Limit shown in the Schedule of Benefits.]; and
- 4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
 - a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
 - b. primarily dependent upon **you** for support and maintenance; and
 - c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:
 - a. joint mortgage or joint tenancy on a residential lease;
 - b. joint bank account;
 - c. joint liabilities (e.g. credit cards or car loans);
 - d. joint ownership of significant property (e.g. cars, land, etc.)
 - e. naming of each other as primary beneficiary in wills or life insurance policies;
 - f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
 - g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner.**]

Illness

Your medically determinable sickness, disease or pregnancy.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **vision providers** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **vision provider's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

Member Vision Provider

A **vision provider** who has entered into a written agreement with an organization that **we** have contracted with to provide vision services.

Vision Insurance

Defined Terms

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Non-Member Vision Provider

A **vision provider** who has not entered into a written agreement with an organization that **we** have contracted with.

Vision Provider

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials.

Effective Date of your Vision Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **your** enrollment is received by **us**, if **you** enroll after 31 days of **your eligibility date**.]

[When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll after 31 days of **your eligibility date**.]

[Actively at Work Requirement does not apply to retirees.]

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. [**You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group vision plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group vision plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group vision plan.]

Termination of your Vision Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date][the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence.

You will not be eligible to re-enroll if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness, or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness**, or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a

[temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group vision insurance plan (the “Prior Plan”); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][injury][,][or][illness][,][or][other leave of absence], on the effective date of the **policy**, **we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your coverage** under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work**. During the Continuity of Coverage **we** will provide limited **coverage** under the **policy**. **Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your coverage** is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy**.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Vision Coverage – for your Dependents]

Effective Date of your Dependent Vision Coverage

If **your covered employer** pays 100% of the cost of **your dependent coverage** under the **policy**, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Vision Coverage; and
2. the Enrollment Requirement for your Dependent Vision Coverage.

When you have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the date **your dependent** is eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your dependent coverage** under the **policy** or if **you** pay 100% of the cost, **your dependent coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Vision Coverage; and
2. the Enrollment Requirement for your Dependent Vision Coverage.

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. the date **you** enrollment is received by **us**, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

[When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** on or before that date or within 31 days after **your dependent's eligibility date**; or
2. on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits, if **you** enroll for **dependent coverage** after 31 days of **your dependent's eligibility date**.]

Coverage for a newborn will be effective from the moment of birth if **you** are already covered for **dependent child coverage** when the **child** is born. If the newborn is **your** first eligible **dependent** or **you** are only covered for **dependent spouse coverage** when the **child** is born, **we** will cover the **child** for the first 90 days from the moment of birth. To continue the **child's coverage** past the first 90 days, **you** must enroll the newborn within 90 days of the date the **child** is born.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if **you** apply for **coverage** within 60 days after the filing of the petition for adoption. **Coverage** will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

[Vision Coverage – for your Dependents]

Eligibility Requirement for your Dependent Vision Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Vision Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective. [**You** can enroll **your dependents** only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **your dependent** becomes eligible for **coverage**. If **your dependents** lose **coverage** under another group vision plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **your dependents** were covered under the other group vision plan at the time of such loss of **coverage**, **your dependents** can enroll within 31 days of termination under the prior group vision plan.]

Termination of your Dependent Vision Coverage

Coverage for **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

Your dependents will not be eligible to re-enroll under the **policy** if **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.]; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **member vision provider**. Benefits may be lower if **you** incur Qualifying Vision Expenses from a **non-member vision provider**.

We will pay benefits for Qualifying Vision Expenses incurred by **you** [or **your covered dependents**] as shown in the Description of Qualifying Vision Expenses. All benefits are paid after **you** satisfy the copayment and will be based on the Schedule of Benefits.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Vision Expenses and are subject to all other provisions of this **coverage**.

Qualifying Vision Expenses

Qualifying Vision Expenses are charges for vision supplies or services made on behalf of **you** [or **your covered dependents**] that are:

1. listed in the Description of Qualifying Vision Expenses;
2. incurred while **coverage** is effective; and
3. recommended by a **vision provider** for treatment that commences after **coverage** becomes effective, except as provided in Limitations and Exclusions.

Qualifying Vision Expenses are incurred on the earliest of the date the service was performed or the date the supply was purchased.

The Qualifying Vision Expenses for vision procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-member vision providers** or the fee schedule amount for **member vision providers**.

Vision procedures not listed as Qualifying Vision Expenses are not covered.

Coordination of Benefits

If **you** [or **your covered dependents**] have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred provider organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing vision benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare

- plan, employer organization plan or employee benefit organization plan or any other arrangement of benefits for individuals of a group;
or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any vision care service or expense, including any deductible or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you** [or **your covered dependent**] as an employee is primary to a plan insuring **you** [or **your covered dependent**] as a **dependent**.
3. a plan insuring **you** [or **your covered dependent**] as an employee is primary to a plan insuring **you** [or **your covered dependent**] as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you** [or **your covered dependent**] for the longer period of time will pay before a plan insuring **you** [or **your covered dependent**] for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR CHILDREN COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:
 - a. not divorced; or
 - b. not separated (whether or not they have ever been married to each other); or
 - c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.
3. If the parents are divorced or separated, the order of benefit payment will be as follows:
 - a. the plan of the parent with primary physical custody;
 - b. the plan of the spouse of the parent with primary physical custody;
 - c. the plan of the non-custodial parent;
 - d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Vision Expenses

Description of Qualifying Vision Expenses

EYE EXAMINATION

Complete initial vision analysis, including appropriate examination of visual functions and prescription of corrective eyewear where indicated. Eye examinations are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

EYEGLOSS LENSES

Standard lenses, including glass or plastic single vision, bifocal, trifocal or lenticular lenses are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

FRAMES

Frames are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

CONTACT LENSES

Contact lenses are provided in lieu of eyeglass lenses and frames as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

LOW VISION SERVICES

Low vision services include supplemental testing, low vision prescription services, evaluations, optical and non-optical aids and training. Low vision services are covered as indicated in the Low Vision Services section of the Schedule of Benefits.

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
 - a. not listed in the Description of Qualifying Vision Expenses;
 - b. not prescribed by or performed by or under the direct supervision of a **vision provider**;
 - c. not visually necessary to restore or maintain a patient's visual acuity and health;
 - d. not meeting the accepted standards of vision practice;
 - e. experimental in nature; or
 - f. covered under any medical insurance policy.
2. Orthoptics or vision training and any associated supplemental testing.
3. Plano lenses (less than a $\pm .50$ diopter power).
4. Two pair of glasses in lieu of bifocals.
5. Medical or surgical treatment of the eyes.
6. Replacement of lenses, frames or contacts furnished under this **policy** that are lost or broken, except at the normal intervals when services are otherwise available.
7. Corneal refractive therapy or orthokeratology.
8. Artistically painted contact lenses.
9. Additional office visits for contact lens pathology.
10. Contact lens modification, polishing or cleaning.
11. Charges for service agreements or insurance policies.
12. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
13. Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form.
14. Codes that are by report.
15. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **vision provider** to that of another during the course of treatment, or if more than one **vision provider** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **vision provider** performed the service.
2. This **policy** is designed to cover visual needs rather than cosmetic materials. If **you** select any of the following, **we** will pay the basic cost of the allowed lenses: optional cosmetic processes; anti-reflective coating; color coating; mirror coating; scratch coating; blended lenses; cosmetic lenses; laminated lenses; oversize lenses; photochromic lenses, tinted lenses except Pink #1 and Pink #2; progressive multifocal lenses; UV (ultraviolet) protected lenses; certain limitations on low vision care.

Notice

We encourage **you** to submit **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss for a **non-member provider**. **You** may obtain a claim form by accessing [www.vsp.com] or by contacting [Member Services at 800-877-7195]. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
-

2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Voluntary Vision Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[October 1 – October 31]
[Work Hours Required for Eligibility]	Your regularly scheduled work hours must be at least [30] hours per week.]
Waiting Period	<p>For your coverage: [90] [days] [months] [For your dependent coverage: [90] [days] [months]]</p> <p>[Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.]</p> <p>[There will be no waiting period for employees who are actively at work and are part of the initial enrollment.]</p>
Your Premium Contribution	You are required to pay the entire premium for coverage .
Frequency	<p>[Covered Dependent Children, under age 19:</p> <p>Eye Examination: One visit every [12] months Eyeglass Lenses: One pair every [12] months Frames: One frame every [12] months Elective Contact Lenses: One pair every [12] months in lieu of eyeglass lenses and frame]</p> <p>[You and your covered dependents, age 19 and over:]</p> <p>Eye Examination: One visit every [12] months Eyeglass Lenses: One pair every [12] months Frames: One frame every [12] months Elective Contact Lenses: One pair every [12] months in lieu of eyeglass lenses and frame</p>

Voluntary Vision Insurance

Schedule of Benefits

Vision Benefit

Vision Benefit	Member Vision Provider	Non-Member Vision Provider
[Eye Examination:	100% after \$[15] copay	\$[45], \$[15] copay applies
Eyeglass Lenses:		
Single Vision	100% after \$[25] material copay	\$[45], \$[25] material copay applies
Bifocal	100% after \$[25] material copay	\$[65], \$[25] material copay applies
Trifocal	100% after \$[25] material copay	\$[85], \$[25] material copay applies
Lenticular	100% after \$[25] material copay	\$[85], \$[25] material copay applies
Frame:	\$[120] after \$[25] material copay	\$[47], \$[25] material copay applies

[\$25] material copay amount is combined for Eyeglass Lenses and Frame.]

[Eye Examination:	100% after \$[25] combined copay	\$[45], \$[25] combined copay applies
Eyeglass Lenses:		
Single Vision	100% after \$[25] combined copay	\$[45] \$[25] combined copay applies
Bifocal	100% after \$[25] combined copay	\$[65], \$[25] combined copay applies
Trifocal	100% after \$[25] combined copay	\$[85], \$[25] combined copay applies
Lenticular	100% after \$[25] combined copay	\$[85], \$[25] combined copay applies
Frame:	\$[120] after \$[25] combined copay	\$[47], \$[25] combined copay applies

[\$25] copay amount applies to the Eye Examination, Eyeglass Lenses, or Frame, whichever is received first.]

Elective Contact Lenses (in lieu of eyeglass lenses and frame):	\$[120]	\$[105]
---	---------	---------

Voluntary Vision Insurance

Schedule of Benefits

Low Vision Services

Low Vision Supplemental Testing:

Member Vision Provider
Covered in full years

Non-Member Vision Provider
up to \$[125] every [2]

Low Vision Aids:

[75]% up to \$[1,000] every [2] years, less any amount paid for supplemental testing

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness, or other Leave of Absence

[Temporary Layoff – [Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.] [Up to [3] months after **your** last day of **active work**.]

Injury or Illness – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

[Dependent Vision Coverage

[Not] Included]

[Dependent Student Age Limit

[23 years]]

Child

Your natural, adopted, foster, or step-child.

An “adopted child” is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A “step-child” is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage**.]

[Dependent

Your:

1. spouse;
2. unmarried **children** from [birth to age 19] [who are primarily dependent upon **you** for support and maintenance];
- [3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
 - a. a full-time student at an accredited school;
 - b. primarily dependent upon **you** for support and maintenance;
 - c. not married; and
 - d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;

and

- [4.] **child** after their [19th] birthday if the **child** has been continuously insured and is:
 - a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
 - b. primarily dependent upon **you** for support and maintenance; and
 - c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

A **child** will also be considered a **dependent** if **you** are ordered by a court to provide **coverage** for that **child** and the **child** meets all conditions for eligibility under the **policy**.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:
 - a. joint mortgage or joint tenancy on a residential lease;
 - b. joint bank account;
 - c. joint liabilities (e.g. credit cards or car loans);
 - d. joint ownership of significant property (e.g. cars, land, etc.);
 - e. naming of each other as primary beneficiary in wills or life insurance policies;
 - f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
 - g. commitment to a long term relationship with the intention of remaining together indefinitely.

Unless otherwise noted, all references to spouse include **domestic partner**.]

Illness

Your medically determinable sickness, disease or pregnancy.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Maximum Allowance

The allowance as determined by **us** to be an appropriate fee for the services or supplies provided.

In determining the **maximum allowance**, **we** may refer to various data regarding what similar **vision providers** accept for similar services under governmental plans, managed care plans and other plans with negotiated fees. **We** will determine what constitutes the same services or supplies and what constitutes the same geographic area. NOTE: To the extent that a **vision provider's** charge exceeds the **maximum allowance**, that amount will not be paid by **us** and will be **your** responsibility.

Voluntary Vision Insurance

Defined Terms

Member Vision Provider

A **vision provider** who has entered into a written agreement with an organization that **we** have contracted with to provide vision services.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**.

Non-Member Vision Provider

A **vision provider** who has not entered into a written agreement with an organization that **we** have contracted with.

Vision Provider

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials.

Effective Date of your Vision Coverage

Your coverage or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown on the Schedule of Benefits.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after **you** become eligible for **coverage**. If **you** lose **coverage** under another group vision plan due to termination of **your** spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and **you** were covered under the other group vision plan at the time of such loss of **coverage**; **you** can enroll within 31 days of termination under the prior group vision plan.

Termination of your Vision

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

Coverage

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date] [the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **you** will be eligible to re-enroll one time.

Continuation of Coverage during [Temporary Layoff], Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will not apply a new **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group vision insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the

effective date of the **policy**.

If **you** are absent from work due to [temporary layoff][,][or][**injury**][,][or][**illness**][,][or][other leave of absence], on the effective date of the **policy**, **we** will provide Continuity of Coverage. Continuity of Coverage will apply if **your coverage** under the Prior Plan was substantially the same as **your coverage** under the **policy** as if **you** were **actively at work**. During the Continuity of Coverage **we** will provide limited **coverage** under the **policy**. **Your** Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your** coverage is extended or continued under the Prior Plan; or
3. the date **your** coverage would end according to the terms of the **policy**.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will be deferred until **you** return to **active work** for at least 1 full day.]

[Vision Coverage – for your Dependents]

Effective Date of your Dependent Vision Coverage

Your dependent coverage or any new coverage will become effective when you have satisfied the following:

1. the Eligibility Requirement for your Dependent Vision Coverage; and
2. the Enrollment Requirement for your Dependent Vision Coverage; and
3. you have paid the first premium for that dependent when due.

When you have satisfied the above requirements, your dependent will be covered at 12:00 a.m. on the date your dependent is eligible for coverage.

If you enroll your dependent more than 31 days after your dependents become eligible, your dependent coverage will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.

Coverage for a newborn will be effective from the moment of birth if you are already covered for dependent child coverage when the child is born. If the newborn is your first eligible dependent or you are only covered for dependent spouse coverage when the child is born, we will cover the child for the first 90 days from the moment of birth. To continue the child's coverage past the first 90 days, you must enroll the newborn within 90 days of the date the child is born or during the Open Enrollment Period.

Coverage for an adopted child will be effective from the date of the filing of a petition for adoption if you apply for coverage within 60 days after the filing of the petition for adoption. Coverage will begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the child.

Eligibility Requirement for your Dependent Vision Coverage

If you enroll your dependents within 31 days after your dependents become eligible, your dependent coverage will become effective on the date you have satisfied the following:

1. your coverage is in effect; and
2. your eligible class provides for dependent coverage; and
3. a person meets the definition of your dependent; and
4. you have completed the waiting period for dependent coverage.

Enrollment Requirement for your Dependent Vision Coverage

You can enroll your dependents only during the Open Enrollment Period shown in the Schedule of Benefits or within 31 days after your dependent becomes eligible for coverage. If your dependents lose coverage under another group vision plan due to termination of your spouse's employment, death, divorce, loss of eligibility under the other plan or termination of the other plan; and your dependents were covered under the other group vision plan at the time of such loss of coverage, your dependents can enroll within 31 days of termination under the prior group vision plan.

Termination of your Dependent Vision Coverage

Coverage for your dependents will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
2. the date **your dependent coverage** is discontinued under the **policy**; or
3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**; or
4. the last date for which **you** make the required premium payment.

If **you** voluntarily terminate **coverage** or **coverage** terminates because **your** required premium contribution is not paid when due, **your dependents** will be eligible to re-enroll one time.

If **you** die while insured, **we** will continue **dependent** benefits for those of **your dependents** who were covered under the **policy** when **you** died. **We** will do this for 6 months at no cost, provided:

1. the **policy** remains in force; and
2. the **dependents** remain eligible **dependents**; and
3. in the case of a spouse, the spouse does not remarry[.]; and]
4. [in the case of a **domestic partner**, the **domestic partner** does not marry or establish another domestic partnership.]

Benefit Payment

IMPORTANT NOTICE: To maximize **your** benefits, **you** should see a **member vision provider**. Benefits may be lower if **you** incur Qualifying Vision Expenses from a **non-member vision provider**.

We will pay benefits for Qualifying Vision Expenses incurred by **you** [or **your covered dependents**] as shown in the Description of Qualifying Vision Expenses. All benefits are paid after **you** satisfy the copayment and will be based on the Schedule of Benefits.

All benefits are subject to the maximums and other limits shown in the Schedule of Benefits and the Description of Qualifying Vision Expenses and are subject to all other provisions of this **coverage**.

Qualifying Vision Expenses

Qualifying Vision Expenses are charges for vision supplies or services made on behalf of **you** [or **your covered dependents**] that are:

1. listed in the Description of Qualifying Vision Expenses;
2. incurred while **coverage** is effective; and
3. recommended by a **vision provider** for treatment that commences after **coverage** becomes effective, except as provided in Limitations and Exclusions.

Qualifying Vision Expenses are incurred on the earliest of the date the service was performed or the date the supply was purchased.

The Qualifying Vision Expenses for vision procedures are the lesser of:

1. the actual charge; or
2. the **maximum allowance** for **non-member vision providers** or the fee schedule amount for **member vision providers**.

Vision procedures not listed as Qualifying Vision Expenses are not covered.

Coordination of Benefits

If **you** [or **your covered dependents**] have other **coverage** that also pays for the benefits provided under the **policy**, **we** will coordinate **our** payment with the benefits from the other plan. This means that benefits payable under the **policy** may be reduced, as described below, so that **you** will receive no more than 100% of the total charge or the preferred provider organization's allowed charge. **We** will first determine whether the **policy** is primary or secondary. If **we** are the primary plan, **we** will pay benefits as if the secondary plan does not exist. If **we** are secondary, **we** will pay benefits based on the payment made by the primary plan.

For purposes of Coordination of Benefits a "plan" is a plan providing vision benefits or services through:

1. group insurance or any other arrangement of coverage for persons in a group either on an insured or self-funded basis; or
2. coverage under a labor-management trusted plan, union welfare plan, employer organization plan or employee benefit organization

- plan or any other arrangement of benefits for individuals of a group;
or
3. any governmental program other than Medicare or Medicaid.

The term "plan" is applied separately to each part of any plan, contract or other arrangement that has the right to take the benefit or services of other plans into consideration in determining its benefits, as opposed to those parts that do not.

An allowable expense for purposes of Coordination of Benefits is any vision care service or expense, including any deductible or copayment, that is covered at least in part by any of the plans covering the person. When a plan provides services instead of cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, whether or not a claim is filed under that plan.

GENERAL RULES FOR BENEFIT PAYMENT

The rules for establishing the order of benefit payments are:

1. a plan without a Coordination of Benefits provision is always primary.
2. a plan insuring **you [or your covered dependent]** as an employee is primary to a plan insuring **you [or your covered dependent]** as a **dependent**.
3. a plan insuring **you [or your covered dependent]** as an employee is primary to a plan insuring **you [or your covered dependent]** as a laid-off or retired employee or a **dependent** of such employee. (This does not apply if either plan does not have a provision for laid-off or retired employees.)
4. a plan insuring **you [or your covered dependent]** for the longer period of time will pay before a plan insuring **you [or your covered dependent]** for the shorter period of time.
5. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans.

RULES FOR BENEFIT PAYMENT FOR CHILDREN COVERED UNDER MORE THAN ONE PLAN

1. If the parents are:
 - a. not divorced; or
 - b. not separated (whether or not they have ever been married to each other); or
 - c. a court decree awards joint custody without specifying which parent has the responsibility for providing health care coverage,

then the primary plan is the plan of the parent whose month and date of birth occurs earlier in the **calendar year**. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the terms of a court decree state that one of the parents is

responsible for the **child's** health care expenses or health coverage, the plan of that parent is primary.

3. If the parents are divorced or separated, the order of benefit payment will be as follows:
 - a. the plan of the parent with primary physical custody;
 - b. the plan of the spouse of the parent with primary physical custody;
 - c. the plan of the non-custodial parent;
 - d. the plan of the spouse of the non-custodial parent.

FACILITY OF PAYMENT

The **policy** may repay other plans for benefits paid that **we** determine should have been paid. That payment will be treated as though it were a benefit paid under the **policy**.

RIGHT OF RECOVERY

We may pay benefits that should have been paid by another benefit plan. In this case **we** may recover the amount paid from the other benefit plan or the **covered person**. That payment will be treated as though it were a benefit paid under the other benefit plan.

Description of Qualifying Vision Expenses

Description of Qualifying Vision Expenses

EYE EXAMINATION

Complete initial vision analysis, including appropriate examination of visual functions and prescription of corrective eyewear where indicated. Eye examinations are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

EYEGLOSS LENSES

Standard lenses, including glass or plastic single vision, bifocal, trifocal or lenticular lenses are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

FRAMES

Frames are covered as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

CONTACT LENSES

Contact lenses are provided in lieu of eyeglass lenses and frames as indicated in the Vision Benefit section of the Schedule of Benefits. Frequency is calculated based on the date services were last received.

LOW VISION SERVICES

Low vision services include supplemental testing, low vision prescription services, evaluations, optical and non-optical aids and training. Low vision services are covered as indicated in the Low Vision Services section of the Schedule of Benefits.

Limitations and Exclusions

We will not pay or provide alternate benefits for any of the following:

1. Items, treatments or services:
 - a. not listed in the Description of Qualifying Vision Expenses;
 - b. not prescribed by or performed by or under the direct supervision of a **vision provider**;
 - c. not visually necessary to restore or maintain a patient's visual acuity and health;
 - d. not meeting the accepted standards of vision practice;
 - e. experimental in nature; or
 - f. covered under any medical insurance policy.
2. Orthoptics or vision training and any associated supplemental testing.
3. Plano lenses (less than a $\pm .50$ diopter power).
4. Two pair of glasses in lieu of bifocals.
5. Medical or surgical treatment of the eyes.
6. Replacement of lenses, frames or contacts furnished under this **policy** that are lost or broken, except at the normal intervals when services are otherwise available.
7. Corneal refractive therapy or orthokeratology.
8. Artistically painted contact lenses.
9. Additional office visits for contact lens pathology.
10. Contact lens modification, polishing or cleaning.
11. Charges for service agreements or insurance policies.
12. Charges for sterilization of equipment; disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
13. Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form.
14. Codes that are by report.
15. Ancillary charges, including but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.

Benefits are limited as follows:

1. In the event **you** transfer from the care of one **vision provider** to that of another during the course of treatment, or if more than one **vision provider** performs services for one qualifying expense, **we** shall be liable for not more than the amount **we** would have been liable for had but one **vision provider** performed the service.
2. This **policy** is designed to cover visual needs rather than cosmetic materials. If **you** select any of the following, **we** will pay the basic cost of the allowed lenses: optional cosmetic processes; anti-reflective coating; color coating; mirror coating; scratch coating; blended lenses; cosmetic lenses; laminated lenses; oversize lenses; photochromic lenses, tinted lenses except Pink #1 and Pink #2; progressive multifocal lenses; UV (ultraviolet) protected lenses; certain limitations on low vision care.

Notice

We encourage **you** to submit **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the expenses are incurred, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss for a **non-member provider**. **You** may obtain a claim form by accessing [www.vsp.com] or by contacting [Member Services at 800-877-7195]. These forms will be supplied to **you** within 15 days of notice of the claim.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the treatment.

Proof of Loss

You must send **us** a proof of loss within 90 days after the date the expenses are incurred.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**.

Payment of Claims

All benefits are payable to **you**. All or any portion of any benefits provided may be paid directly to the person rendering the service.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written

proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180 days] after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [60 days] after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

SERFF Tracking Number: SLIA-127064669 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48166
 Company Tracking Number:
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: Premier Choice - Vision
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/09/2011
Comments:		
Attachments:		
AR Certificate of Readability - Vision.pdf		
AR Certificate of Compliance - Vision.pdf		
AR Consumer Notice.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/09/2011
Comments:		
This application is pending approval - SLIA-127053875		
Attachment:		
ERAPP.2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	03/09/2011
Comments:		
Attachment:		
Vision SOV Final revised 2 2011.pdf		

Arkansas Certificate of Readability

I hereby certify, that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
GP2010VBP	46.4
GP2010VVBP	46.6



Bryan Anderson, Executive VP - Operations

March 4, 2011

Date

Arkansas Certificate of Compliance

I hereby certify that Security Life Insurance Company of America will adhere to and comply with the following:

1. Pursuant to Rule and Regulation 49, the Life and Health Guaranty Notice will accompany every policy issued in the State of Arkansas; and
2. This submission meets the provisions of Rule and Regulation 19, as well as all applicable requirements of the Department; and
3. Pursuant to ACA 23-79-138 and Bulletin 11-88, the Arkansas Consumer Information Notice will accompany every policy issued in the State of Arkansas.



Bryan Anderson, Executive VP - Operations

March 4, 2011
Date

ARKANSAS CONSUMER INFORMATION NOTICE

If we at Security Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494 or (501) 371-2640

PLEASE PRINT CLEARLY

General Information		
Employer's Full Legal Name (exactly as it will appear in the Contract): _____		
Coverages Requested (complete and attach an addendum for each coverage selected): <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Business is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
State of Incorporation: _____		
Tax ID Number:	Years in Business:	
Nature of Business:	SIC Code:	
For groups with 2 to 9 eligible employees: Is this a home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No	For groups with 2 to 9 eligible employees: Are 90% or more of the employees <input type="checkbox"/> Yes <input type="checkbox"/> No in the same family?	
Complete Street Address: Street _____ City _____ State _____ Zip _____ County _____		
Complete Mailing Address (if different): Street _____ City _____ State _____ Zip _____ County _____		
Contact Person:	Title:	
Email:	Telephone Number:	Fax Number:
Who should receive the initial Certificates and Administration Materials? <input type="checkbox"/> Employer— <i>Email required:</i> _____ <input type="checkbox"/> Producing Agent		
Type of Bill Requested: <input type="checkbox"/> List Bill <input type="checkbox"/> Self-Administered (Not available to groups <100 lives or groups applying for Dental or Vision)		
Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly (Not available for Dental or Vision)		
Easy-Pay Method (electronic transfer of premium): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, then Form# [EZPAY2008] must be completed.		

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: No Yes; if Yes, complete the following:

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

FRAUD STATEMENT: 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit, if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY

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

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Declarations**APPLICANT'S DECLARATION**

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

Signature of Officer or Owner

Print Name of Officer or Owner

Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

Signature of Agent

Print Name of Agent

Date

Address:

Telephone #:

License #:

Email:

HOME OFFICE USE:

Vision Statement of Variability

Policy form number – GP2010VSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Original effective date of group contract.
1	Plan Effective Date	Effective date of current group coverage.
1	Open Enrollment Period	Date range will be included based on the selection by the policyholder on the application.
1	Work Hours Required for Eligibility	Hours variable will range from [15-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0-24]. 1 st variable statement is included if there is dependent coverage 2 nd variable statement is included if the effective date is the first of the month after the waiting period 3 rd variable statement is included standard, optional to remove at policyholder request.
1	Your Premium Contribution	[Not] variable depends on whether or not you are required to contribute to coverage. Second sentence included if there is dependent coverage.
1	Frequency	Variable statements included based on dependent coverage Eye exam months variable will range from [12-36]. Lenses months variable will range from [12-36]. Frames months variable will range from [12-36]. Contact lenses months variable will range from [12-36].
2	Vision Benefit	Variable statement will be included based on policyholder selection of separate exam & material co-pays or the selection of a combined exam & material co-pay. Variable dollars ranges for Member Vision Provider . Eye exam copay will range from [\$0-\$30]. Lenses & Frames (material) copays will range from [\$0-\$30]. Frames will range from [\$120-\$200]. Eye exam, Lenses & Frames (combined) copay will range from [\$0-\$30]. Frames will range from [\$120-\$200]. Contact Lenses will range from [\$120-\$200]. Variable dollars ranges for Non-Member Vision Provider . Eye exam will range from [\$45-\$75] and copay will range from [\$0-\$30]. Single Vision Lenses will range from [\$45-\$150] Bifocal Lenses will range from [\$65-\$150] Trifocal Lenses will range from [\$85-\$150]

		<p>Lenticular Lenses will range from [\$85-\$200] Lenses & Frames (material) copay will range from [\$0-\$30]. Frames will range from [\$47-\$200].</p> <p>Eye exam will range from [\$45-\$75] and Exam, Lenses & Frames (combined) copay will range from [\$0-\$30]. Single Vision Lenses will range from [\$45-\$150] Bifocal Lenses will range from [\$65-\$150] Trifocal Lenses will range from [\$85-\$150] Lenticular Lenses will range from [\$85-\$200] Frames will range from [\$47-\$200]. Contact lenses will range from [\$105-\$175].</p>
3	Low Vision Services	<p>Dollar amount will range from [\$125-\$200] and years will range from [1-4]. Percentage will range from [75-100], dollar will range from [\$1000-\$2000] and years will range from [1-4].</p>
3	Continuation of Coverage Period during Injury, Illness, [Temporary Layoff] or Leave of Absence	<p>Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy. Months variable will range from [1-12]</p>
3	Dependent Coverage	<p>Section will be included if there is dependent coverage or will not be included.</p>
3	Dependent Student Age Limit	<p>Section will be included if there is a Dependent Student Age Limit selected by policyholder. Age will range from [23-27].</p>

Policy form number – GP2010VBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Statement will be included if there is dependent coverage.
1	Dependent	<p>Section will be included if there is dependent coverage. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.</p>
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Vision Coverage – for you

4	Effective Date of your Vision Coverage	<p>1st variable statement is included if there is open enrollment. 2nd variable statement is included if there is not open enrollment 3rd variable statement included if there is retiree coverage.</p>
5	Enrollment Requirement	Variable statements will be included if there is Open Enrollment.

5	Termination of your Vision Coverage	#5 – one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by the policyholder to match their HR policy.
5	Continuation of Coverage during Injury, Illness [Temporary Layoff] or Leave of Absence	Temporary Layoff statement will be included if selected by policyholder.
6	Continuity of Coverage	Section included standard, but is optional to remove if requested by the policyholder. Variable statements will be included based upon policyholder HR policy.

Vision Coverage – for your Dependents

7	Vision Coverage – for your Dependents	Variable section will be included if there is Dependent coverage.
8	Enrollment Requirement for your Dependent Vision Coverage	Variable statement will be included if there is an Open Enrollment period.
8	Termination of your Dependent Vision Coverage	Variable statement will be included if coverage included for Domestic Partner.

Vision Benefit

9	Benefit Payment	Variable statement will be included if there is dependent coverage.
9	Qualifying Vision Expenses	Variable statement will be included if there is dependent coverage.
9 – 11	Coordination of Benefits	Variable statement will be included if there is dependent coverage.

Claim Provisions

14	Forms	Information bracketed to accommodate any change in telephone number or website address.
15	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.

Policy form number – GP2010VVS

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Original effective date of group contract.
1	Plan Effective Date	Effective date of current group coverage.
1	Open Enrollment Period	Date range will be included based on the selection by the policyholder on the application.
1	Work Hours Required for Eligibility	Hours variable will range from [15-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0-24]. 1 st variable statement is included if there is dependent coverage.

		<p>2nd variable statement is included if the effective date is the first of the month after the waiting period.</p> <p>3rd variable statement is included standard, optional to remove at policyholder request.</p>
1	Frequency	<p>Variable statements included based on dependent coverage</p> <p>Eye exam months variable will range from [12-36].</p> <p>Lenses months variable will range from [12-36].</p> <p>Frames months variable will range from [12-36].</p> <p>Contact lenses months variable will range from [12-36].</p>
2	Vision Benefit	<p>Variable statement will be included based on policyholder selection of separate exam & material co-pays or the selection of a combined exam & material co-pay.</p> <p>Variable dollars ranges for Member Vision Provider.</p> <p>Eye exam copay will range from [\$0-\$30].</p> <p>Lenses & Frames (material) copays will range from [\$0-\$30].</p> <p>Frames will range from [\$120-\$200].</p> <p>Eye exam, Lenses & Frames (combined) copay will range from [\$0-\$30].</p> <p>Frames will range from [\$120-\$200].</p> <p>Contact Lenses will range from [\$120-\$200].</p> <p>Variable dollars ranges for Non-Member Vision Provider.</p> <p>Eye exam will range from [\$45-\$75] and copay will range from [\$0-\$30].</p> <p>Single Vision Lenses will range from [\$45-\$150]</p> <p>Bifocal Lenses will range from [\$65-\$150]</p> <p>Trifocal Lenses will range from [\$85-\$150]</p> <p>Lenticular Lenses will range from [\$85-\$200]</p> <p>Lenses & Frames (material) copay will range from [\$0-\$30].</p> <p>Frames will range from [\$47-\$200].</p> <p>Eye exam will range from [\$45-\$75] and Exam, Lenses & Frames (combined) copay will range from [\$0-\$30].</p> <p>Single Vision Lenses will range from [\$45-\$150]</p> <p>Bifocal Lenses will range from [\$65-\$150]</p> <p>Trifocal Lenses will range from [\$85-\$150]</p> <p>Lenticular Lenses will range from [\$85-\$200]</p> <p>Frames will range from [\$47-\$200].</p> <p>Contact lenses will range from [\$105-\$175].</p>
3	Low Vision Services	<p>Dollar amount will range from [\$125-\$200] and years will range from [1-4].</p> <p>Percentage will range from [75 -100], dollar will range from [\$1000-\$2000] and years will range from [1-4].</p>
	Continuation of Coverage Period during Injury, Illness, [Temporary Layoff] or Leave of Absence	<p>Temporary Layoff and applicable statement will be included if selected by policyholder to match their HR policy.</p> <p>Months variable will range from [1-12]</p>
3	Dependent Coverage	<p>Section will be included if there is dependent coverage or</p>

		will not be included.
3	Dependent Student Age Limit	Section will be included if there is a Dependent Student Age Limit selected. Age will range from [23-27].

Policy form number – GP2010VVBP

Defined Terms

Page #	Provision	Variables
1	Covered Dependent	Statement will be included if there is dependent coverage.
1	Dependent	Section will be included if there is dependent coverage. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
2	Domestic Partner	Section included standard, optional to remove at policyholder request.

Vision Coverage – for you

5	Termination of your Vision Coverage	#5 – one statement will be included and one not included based on policyholder selection on the application. Temporary Layoff will be included if requested by the policyholder to match their HR Policy.
5	Continuation of Coverage during Injury, Illness [Temporary Layoff] or Leave of Absence	Temporary Layoff will be included if selected by policyholder.
5	Continuity of Coverage	Section included standard, but is optional to remove if requested by the policyholder. Variable statements will be included based upon policyholder HR policy.

Vision Coverage – for your Dependents

7	Vision Coverage – for your Dependents	Variable section will be included if there is Dependent coverage
8	Termination of your Dependent Vision Coverage	Variable statement will be included if coverage is included for Domestic Partner.

Vision Benefit

9	Benefit Payment	Variable statement will be included if there is dependent coverage.
9	Qualifying Vision Expenses	Variable statement will be included if there is dependent coverage.
9 – 11	Coordination of Benefits	Variable statement will be included if there is dependent coverage.

Claim Provisions

14	Forms	Information bracketed to accommodate any change in
----	-------	--

		telephone number or website address.
15	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.