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Employer funded and voluntary  
**VISION**  
 insurance for employer groups with 2+ lives.

Underwritten by Security Life Insurance Company of America, 10901 Red Circle Drive, Minnetonka, Minnesota, 55343

- Utilizes VSPs Signature Plan
- No waiting periods
- Choice of multiple plan designs

Vision Benefits - In Network	Plan I	Plan II	Plan III
<b>EYE EXAMINATION</b>			
Frequency	Once every 12 months	Once every 12 months	Once every 12 months
Insured Copay	\$10	\$10	\$10
<b>EYEGLOSS MATERIALS</b>			
Frequency for lenses (including contacts)	Once every 24 months	Once every 12 months	Once every 12 months
Frequency for frames	Once every 24 months	Once every 24 months	Once every 12 months
Insured Copay	\$20*	\$20*	\$20*

\*There is no copay for contacts.  
 In network Vision Benefits are covered 100% after the required copay and may be subject to a maximum allowable.

Vision Benefits - Out of Network	Plan I	Plan II	Plan III
		The plan will pay:	
Eye Examination	\$52 after copay	\$52 after copay	\$52 after copay
Single Vision Lenses	\$55 after copay	\$55 after copay	\$55 after copay
Bifocal Lenses	\$75 after copay	\$75 after copay	\$75 after copay
Trifocal Lenses	\$95 after copay	\$95 after copay	\$95 after copay
Lenticular Lenses	\$125 after copay	\$125 after copay	\$125 after copay
Frame	\$57 after copay	\$57 after copay	\$57 after copay
Contact Lenses	\$105	\$105	\$105

**What the Benefits Include:**

- **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 Product Design Chart. Frequency is calculated based on the date services were last received.
- **Eyeglass Lenses** – Standard lenses, including glass or plastic single vision, bifocal, trifocal or lenticular lenses are covered as indicated in the Product Design Chart. Frequency is calculated based on the date services were last received.
  - Dependent children are eligible for fully covered polycarbonate lenses.
- **Frames** – Frames are covered as indicated in the Product Design Chart. Frequency is calculated based on the date services were last received. There is a \$130 allowance, with a 20% discount on the amount over the allowance.

- **Contact Lenses** – Contact lenses are provided in lieu of eyeglass lenses and frames as indicated in the Product Design Chart. Frequency is calculated based on the date services were last received. There is a \$130 allowance for contacts and the contact lens exam (combined).
- **2 year rate guarantee**
- **Laser VisionCare Program<sup>SM</sup>:**
  - VSP contracted laser centers provide discounts averaging 15% off laser surgery, including photorefractive keratectomy (PRK), laser-assisted in-situ keratomileusis (LASIK) and Custom LASIK.
  - If the laser center is offering a price reduction, VSP members will receive an additional 5% off the promotional price.
- **Low Vision** – Low vision supplemental testing and low vision aids up to \$1,000 are covered every 2 years.

**About VSP:** VSP® Vision Care is the largest not-for-profit, full-service vision benefits provider in the United States with more than 50 years of experience. VSP provides 55 million members with WellVision Exams®, quality eyewear, and personalized care from a national network of 26,000 private-practice doctors and 38,000 access points. Improve the way you see the world with vision care from VSP. To learn more about VSP and to locate a provider near you, visit their website at vsp.com.

Please contact your Agent for more information. To learn more about Security Life: 800.233.0307 or SecurityLife.com/FiveStar

## LIMITATIONS AND EXCLUSIONS

The policy will not cover 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 pairs 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.

\*This is only a summary of benefits and is subject to individual state regulations. For complete information, please see the Certificate of Insurance.

## UNDERWRITING GUIDELINES

### EMPLOYER FUNDED VISION:

#### Minimum Group Size

You can offer this plan if you employ 2 or more full time employees.

#### Eligibility

Your full time employees working 30 or more hours per week are eligible for this plan. Annual open enrollment period required. Employees must enroll within 31 days of becoming eligible or wait for the next open enrollment period. Once in the plan an employee who voluntarily terminates can re-enroll one time at the employer's next scheduled annual open enrollment period.

#### Employer Restrictions

This plan is only available to employers that have been in business more than one year. For employer funded rates you must contribute a minimum of 25% of the employee premium.

Most firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content

Please see rate card for additional information.

#### Minimum Participation Requirements

100% if you pay the full cost of the benefits, with a minimum of 2 enrolled. 75% if your employees contribute toward the cost, with a minimum of 2 enrolled.

### VOLUNTARY VISION:

#### Minimum Group Size

You can offer this plan if you employ 2 or more full time employees.

#### Eligibility

Your full time employees working 30 or more hours per week are eligible for this plan. Annual open enrollment period required. Employees must enroll within 31 days of becoming eligible or wait for the next open enrollment period. Once in the plan an employee who voluntarily terminates can re-enroll one time at the employer's next scheduled annual open enrollment period.

#### Employer Restrictions

This plan is only available to employers that have been in business more than one year.

Most firms will qualify for this plan; however, coverage is not available to:

- Groups funded by the government or any government agency
- Groups that are home based
- Groups that are seasonal in nature
- Groups with more than 90% family content

Please see rate card for additional information.

#### Minimum Participation Requirements

Minimum of 2 enrolled.

## FiveStar Vision Monthly Premium Rates

For Effective Dates September 1, 2011 through March 2012

Group Vision Base Rates		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	
Employer Funded	Plan I	Employee Only	\$ 5.01	\$ 5.41	\$ 5.69	\$ 6.03	\$ 6.49	\$ 7.28
		Employee+Spouse	\$ 10.02	\$ 10.82	\$ 11.39	\$ 12.07	\$ 12.98	\$ 14.58
		Employee+ Child(ren)	\$ 10.33	\$ 11.15	\$ 11.74	\$ 12.44	\$ 13.38	\$ 15.03
		Employee + Family	\$ 15.61	\$ 16.85	\$ 17.74	\$ 18.80	\$ 20.22	\$ 22.71
	Plan II	Employee Only	\$ 6.12	\$ 6.60	\$ 6.95	\$ 7.37	\$ 7.92	\$ 8.90
		Employee+Spouse	\$ 12.22	\$ 13.20	\$ 13.89	\$ 14.72	\$ 15.83	\$ 17.78
		Employee+ Child(ren)	\$ 12.60	\$ 13.60	\$ 14.32	\$ 15.18	\$ 16.32	\$ 18.33
		Employee + Family	\$ 19.05	\$ 20.57	\$ 21.65	\$ 22.95	\$ 24.68	\$ 27.71
	Plan III	Employee Only	\$ 7.57	\$ 8.17	\$ 8.60	\$ 9.12	\$ 9.80	\$ 11.01
		Employee+Spouse	\$ 15.13	\$ 16.33	\$ 17.19	\$ 18.22	\$ 19.60	\$ 22.00
		Employee+ Child(ren)	\$ 15.59	\$ 16.83	\$ 17.72	\$ 18.78	\$ 20.20	\$ 22.68
		Employee + Family	\$ 23.58	\$ 25.45	\$ 26.79	\$ 28.40	\$ 30.54	\$ 34.29
Voluntary	Plan I	Employee Only	\$ 6.01	\$ 6.49	\$ 6.83	\$ 7.24	\$ 7.79	\$ 8.74
		Employee+Spouse	\$ 12.02	\$ 12.98	\$ 13.66	\$ 14.48	\$ 15.57	\$ 17.48
		Employee+ Child(ren)	\$ 12.39	\$ 13.38	\$ 14.08	\$ 14.92	\$ 16.05	\$ 18.02
		Employee + Family	\$ 18.74	\$ 20.23	\$ 21.29	\$ 22.57	\$ 24.27	\$ 27.25
	Plan II	Employee Only	\$ 7.77	\$ 8.39	\$ 8.83	\$ 9.36	\$ 10.07	\$ 11.30
		Employee+Spouse	\$ 14.67	\$ 15.84	\$ 16.67	\$ 17.67	\$ 19.00	\$ 21.34
		Employee+ Child(ren)	\$ 15.12	\$ 16.32	\$ 17.18	\$ 18.21	\$ 19.59	\$ 21.99
		Employee + Family	\$ 22.86	\$ 24.68	\$ 25.98	\$ 27.54	\$ 29.62	\$ 33.25
	Plan III	Employee Only	\$ 9.08	\$ 9.80	\$ 10.32	\$ 10.94	\$ 11.76	\$ 13.21
		Employee+Spouse	\$ 18.15	\$ 19.60	\$ 20.63	\$ 21.87	\$ 23.52	\$ 26.41
		Employee+ Child(ren)	\$ 18.72	\$ 20.21	\$ 21.27	\$ 22.55	\$ 24.25	\$ 27.23
		Employee + Family	\$ 28.29	\$ 30.54	\$ 32.15	\$ 34.08	\$ 36.65	\$ 41.15

### Rate Calculation

Locate your state and area factor in the Vision State Factor Chart to determine the applicable monthly premium based on plan selection

State and Area Factors											
State	Area	State	Area	State	Area	State	Area	State	Area	State	Area
AK	6	GA	5	KY	5	MS	3	OH	3	TN	5
AL	5	IA	2	LA	2	NC	4	OK	4	TX	3
AR	5	ID	4	MD	3	ND	2	OR	4	WI	2
AZ	2	IL	2	MI	3	NE	2	PA	3	WV	5
DC	5	IN	4	MN	2	NM	3	SC	4	WY	3
DE	3	KS	3	MO	3	NV	4	SD	3		