GEMSTAR℠ 1500

Vision Insurance for employer groups with 2+ lives

- No waiting periods
- Rate discount for combined dental and vision package
- Additional network discounts available

Vision Benefits – In Network

	9752007
EXAMINATION	
Frequency	Once every 12 months
Insureds Copay	$10
EYEGLASS LENSES	
Frequency	Once every 12 months
Insureds Copay	$10
FRAMES	
Frequency	Once every 12 months
Insureds Copay	$0
CONTACTS (in lieu of eyeglass lenses)	
Frequency	Same as eyeglass lenses
Insureds Copay	Same as eyeglass lenses

Vision Benefits – Out of Network

	The plan will pay:
Eye Examination	$25
Single Vision Lenses	$20
Bifocal Lenses	$40
Trifocal Lenses	$50
Frames	$40
Contacts (in lieu of eyeglass lenses)	$70

PROUDLY BROUGHT TO YOU BY:

WHAT THE BENEFITS INCLUDE

- **Eye Examination –** A routine, complete eye examination, refraction and prescription for eyeglasses. Contact lens examinations require additional fees. If indicated, your doctor may recommend additional procedures which are the responsibility of the member.
- **Eyeglass Lenses –** Standard uncoated plastic lenses of any size or power.
- **Frames –** Any frame up to a regular retail value of $130. Frames above $130 retail are available at an additional charge.
- **Contact Lenses –** Any pair of contact lenses up to a regular retail price of $130 obtained from a network provider or the mail order program. Contact lenses above $130 are available at an additional charge.
- **LASIK –** Non-insured discount benefit. The EyeMed Access Network provides discounts to insureds interested in LASIK – a laser vision correction procedure. This non-insured benefit is offered at savings of 15% off the regular retail price or 5% off the promotional price when using the network.
- **2 year rate guarantee**
- **EyeMed Access Network –** EyeMed includes such familiar names as LensCrafters, Pearle Vision, Sears Optical and Target Optical along with thousands of independent optometrists, ophthalmologists and opticians. For more information or to find a participating doctor, call 866.723.0513 or visit **EnrollWithEyeMed.com/access**.
- **Additional Lens Option Benefits –** In network only, add to the lens price above and enjoy add-on benefits for a minimum copayment:

Add-Ons	Copayment
UV Coating	$15
Scratch Resistance	$15
Tint	$15
Polycarbonate	$40
Anti-Reflective	$45
Standard Progressive	$65
Other Add-Ons	20% Retail Discount

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

BENEFIT PROVISIONS, LIMITATIONS AND EXCLUSIONS

VISION EXPENSES NOT COVERED

Limitations – In no event will payment exceed the lesser of:

- The actual cost of covered Services or Materials; or
- the limits of the Policy, shown on the coverage schedule.

Exclusions – We will not cover:

- Orthoptic or vision training and any associated supplemental testing;
- plano lenses;
- lens coatings;
- two pairs of glasses, in lieu of bifocals or trifocals;
- medical or surgical treatment of the eyes;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- any injury or illness when covered under any Workers Compensation or similar law, or which is work-related;
- no-line bifocal or progressive lenses;
- photo-chromatic lenses;
- sub-normal vision aids or non-prescription lenses;
- services rendered or Materials purchased outside the U.S. or Canada, unless: a. the Insured resides in the U.S. or Canada; and b. the charges are incurred while on a business or pleasure trip.
- charges in excess of the Usual and Customary charge for the Service or Materials;
- charges incurred after; a. the Policy ends; or b. the Insured's coverage under the Policy ends, except as stated in the Policy;
- experimental or non-conventional treatment or device;
- spectacle lens treatments or "add-ons", except solid tints (#1 and #2), and oversize lenses;
- high index lenses of any material type;
- lost or broken Materials, except when replaced at normal intervals when Services are available.

UNDERWRITING GUIDELINES

ELIGIBILITY

Rates are guaranteed for a period of TWO YEARS from the effective date. Annual open enrollment.

ELIGIBLE EMPLOYEE

An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

ELIGIBLE DEPENDENT

Eligible dependent is any of the following persons:

- Your spouse, and
- Your unmarried child, from birth to age 26.
- Each unmarried child at least 26 years of age who is dependent upon You for support because he is incapable of self-sustaining employment by reason of mental retardation or physical handicap; who was incapacitated and insured under the Policy on his 26th birthday; and who continues to be incapacitated beyond his 26th birthday.

EMPLOYER RESTRICTIONS

This insurance 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

This list of ineligible firms is representative only and not all-inclusive.

GENERAL INFORMATION

PREMIUMS, RENEWABILITY

Applicable Vision Premium Rates are guaranteed for each Employer Group for 24 months from date of issue. Thereafter, rates are subject to change in accordance with the Master Policy. Coverage is renewable as long as eligibility criteria are satisfied and premiums are paid when due.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates: (a) the last day of the month in which You cease to be eligible for coverage; (b) the last day of the month in which Your Dependent is no longer a dependent as defined; (c) subject to the Grace Period, the last day of the month for which a premium has been paid by you or on your behalf; or (d) the date the Master Policy ends.

COORDINATION OF BENEFITS

This insurance plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits.

EFFECTIVE DATE

The insurance for current employees will be effective on the date approved by the insurance company. Future new employees will become insured on the first of the month following the completion of the probationary period selected by the employer. A completed enrollment form must be received within 31 days of new employee eligibility. An employee who does not enroll when initially eligible is considered a "late entrant." A late entrant is eligible to enroll in the program as a "new employee" on the Plan's Anniversary Date or immediately if a qualifying event occurs.

NOT AVAILABLE IN: NH, NJ, NY, VT, WA.

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This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in Group Vision Policy GH-1157 for all states except IL, IA and MN; GH-1154 for IL, IA and MN. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product is subject to individual state regulations. The policyholder may be a trustee group policyholder in some states.

SecurityLife.com • 800.328.4667

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Rates effective October 1, 2013 - December 31, 2014

GemStar 1500 Vision Rates

Follow the steps below to find your **GemStar Vision** monthly policy rate:

1 Find your vision rate by contribution

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Voluntary	$8.25	$15.51	$13.42	$22.11

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Employer Paid*	$7.26	$13.42	$11.55	$19.03

*Requires 75% employer contribution for employee only, or 50% employer contribution for employee + dependent.

2 Find the monthly vision premium for your group

	Base Rate	Discount: Package**	Total Monthly Premium	# of Employees	Subtotal
Employee Only	$	x 0.95	= $	x =	$
Employee + Spouse	$	x 0.95	= $	x =	$
Employee + Child(ren)	$	x 0.95	= $	x =	$
Employee + Family	$	x 0.95	= $	x =	$
				Total Vision Premium for Group	$

***A 5% discount is available for combined dental and vision packages. To receive the discount, at least two employees must sign up for dental coverage and at least two employees must sign up for vision coverage.*

Vision unavailable for NH, NJ, NY, VT, WA.