

<b>Benefit Overview</b>		
	<b>Hi Option</b>	<b>Low Option</b>
<b>Deductible</b> (Calendar Year)	<b>\$50 Per Person</b> <b>\$150 Family</b>	<b>\$50 Individual</b> <b>\$150 Family</b>
<b>Diagnostic &amp; Preventative Services</b> Oral Exams Prophylaxis Bitewing X-Rays Topical Fluoride Sealants Space Maintainers	Deductible Waived  <b>100%</b>	Deductible Waived  <b>100%</b>
<b>Basic Services</b> Simple Restorative Bridge, Denture Repair Simple Extractions Full Mouth X-Rays Emergency Care Treatment	Subject to Deductible  <b>80%</b>	Subject to Deductible  <b>80%</b>
<b>Major Restorative</b> Inlays, Onlays Crowns Bridges/ Dentures Periodontics (Sur) Root Canal Endodontics Periodontics (Adj) Surgical Extractions Oral Surgery Anesthesia	Subject to Deductible 12 Month Waiting Period  <b>50%</b>	<b>No Coverage</b>
<b>Annual Maximum</b>	<b>\$1,000</b>	<b>\$1000</b>
<b>Orthodontia Services</b> Available to Dependent children under age 19	No Deductible 12 Month Waiting Period <b>50%</b> Lifetime Maximum <b>\$1,000</b>	<b>No Coverage</b>

Eligible Dependents are all children who are not married, who are less than 26 years of age and who live with you and are dependent on you for principal support and maintenance.

<b>Monthly Rates</b>				
	Employee	Employee + Spouse	Employee + Child(ren)	Family
Hi Option	\$29.99	\$54.35	\$75.78	\$98.75
Low Option	\$19.99	\$38.37	\$58.09	\$79.69

Citizens Security Life Insurance Company • PO Box 436149 • Louisville, Kentucky 40253-6149 •

**For providers list please visit our website at [www.CitizensGroup.com](http://www.CitizensGroup.com)**

This is only a brief summary of the benefits of your dental plan. Please refer to your Certificate for a complete description of covered services and any limitations or exclusions that may apply.

## The Collection

Our plans offer members a generous frame allowance to use toward any frame of their choice or the option to choose their frame from our exclusive Collection of over 200 name brand frames. Each comprehensive plan includes a selection of Collection frames that are covered in full (retail value up to \$225).



## Covered-In-Full Contact Lenses

Contact lens wearers will find the same outstanding value and quality with CS Benefits and Davis Vision's Contact Lens Collections, our value-added option to the contact lens allowance. Members who select from our popular Collection of contact lenses receive their evaluations, fitting, follow-up care, and contact lenses – covered up to \$130! To see the full Formulary List of Contacts, please visit us at [www.mycsbenefits.com](http://www.mycsbenefits.com).

## Unparalleled Value on Lens Options

Standard lenses such as single vision, bifocals, trifocals, and lenticular lenses are covered in full, and many extras are included at no cost for members. Plus, many of the most popular lens options are offered at significantly reduced prices.

## Value Added Benefit

Digital Progressive Lens now available at a discounted rates.

## Network Choice

Freedom of choice in selecting a vision provider is a core value to us. We offer out-of-network options to all members. The member is responsible for the difference between the out-of-network provider's charge and the negotiated schedule of a network provider. If a Davis network provider is not available within 30 miles of a member's home or there is no provider that adequately meets the particular health care needs of a member, we allow access to a non-participating provider. In this case, there is no additional cost beyond what the member would normally pay for the same in-network service. To learn more about your network choices, contact us at [www.davisvision.com](http://www.davisvision.com).

Monthly Rates	
Employee	\$7.39
Employee + One	\$13.41
Employee + Family	\$23.30

The industry's only one-year eyeglass breakage warranty!

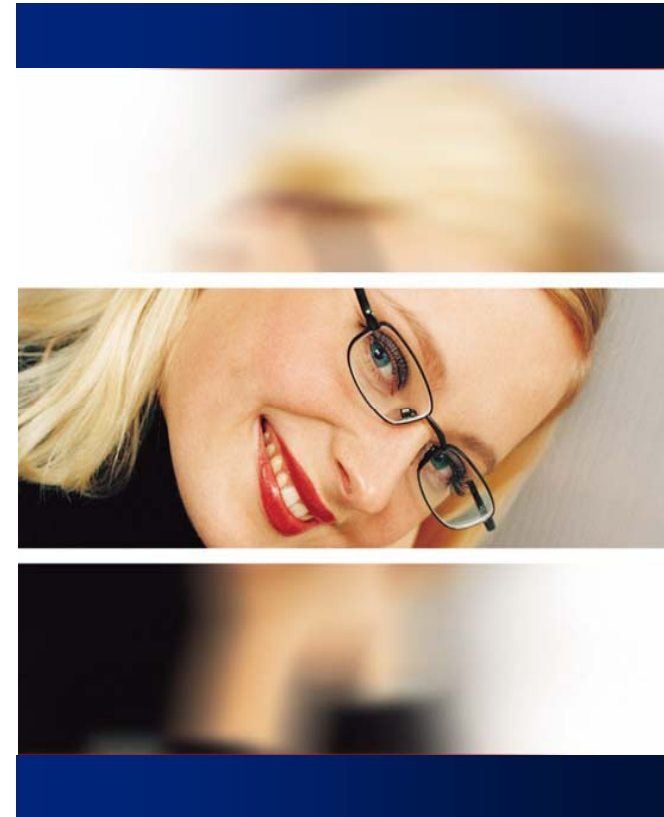


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[www.citizensgroup.com](http://www.citizensgroup.com)

CS GRP V TRI STD 01



## OUR FOCUS



## IS YOUR VISION

Vision Care Plan Benefit  
Description for



## Vision Plan Services & Benefits

### Special Features of Your Davis Vision Plan

#### Low Vision Services:

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up care visits will be covered during the five year period.

#### Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating providers normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit [www.DavisVision.com](http://www.DavisVision.com) or call 800.999.5431.

#### Contact Replacements by Mail

Free membership and access to Lens 123, a mail order replacement contact lens service, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 website at [www.Lens123.com](http://www.Lens123.com).

*This is only a brief summary of the benefits in the Vision Plan. Refer to the Certificate of Insurance for complete details.*

*\* Contact Lenses are available in lieu of frames and lenses. Once lenses are fitted, they cannot be exchanged. Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.*

*\*\* Additional discount does not apply at participating Walmart and Sam's Club locations. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses; however, the co-payment is not refundable.*



Service with a Human Touch.



Benefits	In-Network	Out-Of-Network
Exams (Includes dilation when medically necessary) Co-Pay Frequency	\$10 Co-Pay Once Every 12 months	Reimbursed up to \$40 Once every 12 months
Eyeglass Lenses Co-Pay Frequency Single Bifocal Trifocal Lenticular  Optional Lenses: Oversize Lenses Ultraviolet Coating Scratch-Resistant Blended Segment Polycarbonate Photochromic Glass Intermediate Progressive Multifocal Std Glass Grey#3 Prescription Sunglass Lenses Anti-Reflective Std Anti-Reflective Prem Anti-Reflective Ultra High Index Progressive Multifocal Prem* Plastic Photosensitive Polarized	\$25 Co-Pay Once Every 12 months Paid in Full Paid in Full Paid in Full Paid in Full  Paid in Full \$12 Co-Pay \$20 Co-Pay \$20 Co-Pay *\$0 or \$30 Co-Pay* \$20 Co-Pay \$30 Co-Pay \$50 Co-Pay Paid in Full  \$35 Co-Pay \$48 Co-Pay \$60 Co-Pay \$55 Co-Pay  \$90 Co-Pay \$65 Co-Pay \$75 Co-Pay	Once Every 12 months Reimbursed up to \$40 Reimbursed up to \$60 Reimbursed up to \$80 Reimbursed up to \$80  n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a n/a
Frames Frequency Fashion Collection Designer Collection Premier Collection All Other	Once Every 24 months Paid in Full Paid in Full \$25 Co-Pay  \$130 allowance and 20% discount on excess**	Once Every 24 months n/a n/a n/a  \$65 allowance
Contact Lenses Frequency  Medically Necessary (With Prior Approval) Davis Vision Collection Disposable Planned Replacement Retail Allowance  Evaluation, Fitting, and Follow-Up Davis Vision Collection Non-Collection Standard Non-Collection Specialty	Once Every 12 months  Paid in Full  Paid in Full 4 multi-packs 2 multi-packs \$130 allowance and 15% discount on excess**  Paid in Full 15% discount 15% discount	Once Every 12 months  Reimbursed up to \$225  Reimbursed up to \$105 Reimbursed up to \$105 Reimbursed up to \$105  n/a n/a n/a

\*Polycarbonate lenses COVERED-IN-FULL for dependent children monocular patients and patients with prescriptions  $\geq$  +/- 6.00 diopters\*

Eligible Dependents are all children who are not married, who are less than 26 years of age and who live with you and are dependent on you for principal support and maintenance.

## Vision Q & A

### How do I receive services from a provider in the network?

Simply, call the network provider of your choice and schedule an appointment. Identify yourself as a Davis Vision plan participant. You will be asked to provide the name(s) and date of birth of any covered member needing service. No claim forms are required. Be prepared with your personal I.D. number when you call.

### Who are the network providers?

The Davis Vision network have licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. To Find a Provider, go to [www.mycsbenefits.com](http://www.mycsbenefits.com), click on Vision or call 800.999.5431 to be directed to the network providers nearest you.

### Can I access care at a retail location?

In order to provide our members with the greatest flexibility and convenience, Davis Vision has a number of retail establishments in the provider network. Benefits at retail locations may vary slightly from other locations, as noted in this benefit description.

### What about out-of-network provider benefits?

Although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network, you can choose an out-of-network provider. You must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit  
PO Box 1525  
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. To obtain a claim form, please visit our website at [www.mycsbenefits.com](http://www.mycsbenefits.com).

### Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.
- Two pairs of eyeglasses in lieu of a bifocal.





New   
Change

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I hereby request and authorize \_\_\_\_\_ to initiate debit entries to my checking/ savings account indicated below at the depository financial institution named below, and to credit the same to such account. I acknowledge that the origination of these transactions to my account must comply with the provisions of U.S. law.

I agree that this authorization, unless terminated sooner by the Company, is to remain in effect until receipt by the company of written notice from me of its revocation in such a manner as to afford Company and depository a reasonable opportunity to act on it.

\_\_\_\_\_  
Authorized Signature as it Appears on Bank Records

\_\_\_\_\_  
Date

Name of Depositor(s) as it appears on bank records

Name of Bank

Address of Bank or Branch Office Where Account is Maintained

**ATTACH SAMPLE/ COPY CHECK MARKED  
“VOID”**