INDIANA VISION SERVICES, INC.

PLEASE ATTACH TO YOUR
GROUP VISION CARE PLAN

AMENDMENT TO GROUP VISION CARE PLAN

To be attached to and made part of Group Vision Care Plan Number 30015569 issued to CNO SERVICES, LLC.

EXCEPT as specifically amended herein, said Plan shall remain in full force and effect.

IT IS HEREBY AGREED that effective January 1, 2011, Exhibit A of the Group Vision Care Plan shall be amended as follows:

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of INDIANA VISION SERVICES, INC. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit section below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any unmarried child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

  The domestic partner of the same gender as Enrollee, pursuant to Group's eligibility.

Unmarried dependent children are covered up to the end of the month in which they turn age 24.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $10.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT		FREQUENCY
EYE EXAMINATION	Covered in full*		Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT		FREQUENCY
LENSES			Available once each 12 months**
Single Vision	Covered in full *		
Bifocal	Covered in full *		
Trifocal	Covered in full *		
Lenticular	Covered in full *		
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT		FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Covered in full		

** Beginning with the first day of the Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT		FREQUENCY
FRAMES	Covered up to Plan Allowance*		Available once each 24 months**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT		FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**

Professional Fees/Materials	Covered in full *		
Elective			Available once each 12 months**
Professional Fees/Materials***	Up to $ 120.00		

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

NON-VSP PROVIDERS

PLAN BENEFITS

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
EYE EXAMINATION	Up to $50.00*		Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
LENSES			Available once each 12 months**
Single Vision	Up to $50.00*		
Bifocal	Up to $75.00*		
Trifocal	Up to $100.00*		
Lenticular	Up to $125.00*		
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
LENS OPTIONS			Available once each 12 months**
Scratch coating	Not Covered*		

** Beginning with the first day of the Benefit Period.

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
FRAMES	Up to $70.00*		Available once each 24 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary. *Less any applicable Copayment. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
CONTACT LENSES			
Necessary			Available once each 12 months**
Professional Fees/Materials	Up to $210.00*		
Elective			Available once each 12 months**
Professional Fees/Materials***	Up to $105.00*		

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.

Utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses only were obtained in the current Benefit Period.

SERVICE OR MATERIAL	NON-VSP PROVIDER BENEFIT		FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing	Up to $125.00 (Includes evaluation, diagnosis and prescription of vision aids where indicated.)		*
Supplemental Aids	75% of amount up to $1000.00*		*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.