

SERFF Tracking Number: AMFA-126177338 State: Arkansas
Filing Company: Reliance Standard Life Insurance Company State Tracking Number: 42639
Company Tracking Number: RSL - 9270 VSP REV. 06-09
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: RSL - 9270 VSP Rev. 06-09
Project Name/Number: 9270 VSP Rev. 06-09/9270 VSP Rev. 06-09

Filing at a Glance

Company: Reliance Standard Life Insurance Company

Product Name: RSL - 9270 VSP Rev. 06-09 SERFF Tr Num: AMFA-126177338 State: ArkansasLH
TOI: H10G Group Health - Dental SERFF Status: Closed State Tr Num: 42639
Sub-TOI: H10G.000 Health - Dental Co Tr Num: RSL - 9270 VSP REV. 06-09 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Janis Landon Disposition Date: 06/15/2009
Date Submitted: 06/10/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: 9270 VSP Rev. 06-09 Status of Filing in Domicile: Pending
Project Number: 9270 VSP Rev. 06-09 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
Overall Rate Impact: Group Market Type: Employer
Filing Status Changed: 06/15/2009 Explanation for Other Group Market Type:
State Status Changed: 06/15/2009
Deemer Date: Corresponding Filing Tracking Number:
Filing Description:

Enclosed for your review and approval are the above referenced insert pages, which will be issued for new group policies/certificates issued or renewed after the Department's approval date. These forms will be used with group policy 9000 Rev. 03-08 and group certificate 9021 Rev. 03-08 previously approved by your Department and will replace previously approved forms 9270 EM Ed. 04-06 and 9270 VSP Ed. 04-06.

These forms provide Eye Care Expense Benefits in which the reimbursement for covered services is based on a

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Janis Landon

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst jlandon@ameritas.com
 5900 O Street (800) 745-1112 [Phone]
 Lincoln, NE 68501-1889 (402) 467-7956[FAX]

Filing Company Information

Reliance Standard Life Insurance Company CoCode: 68381 State of Domicile: Illinois
 2001 Market Street Group Code: 74 Company Type:
 Suite 1500
 Philadelphia, PA 19103 Group Name: State ID Number:
 (800) 745-6665 ext. [Phone] FEIN Number: 36-0883760

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reliance Standard Life Insurance Company	\$50.00	06/10/2009	28491022

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/15/2009	06/15/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
TOI	Note To Filer	Rosalind Minor	06/15/2009	06/15/2009
TOI	Note To Reviewer	Janis Landon	06/11/2009	06/11/2009

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Disposition

Disposition Date: 06/15/2009

Implementation Date:

Status: Approved-Closed

Comment: This submission is being approved with the understanding that benefits paid a PPO and Non-PPO will comply with our Bulletin 9-85.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Third Party Authorization	Approved-Closed	Yes
Supporting Document	Optionals and Variables	Approved-Closed	Yes
Form	Eye Care Expense Benefits	Approved-Closed	Yes
Form	Eye Care Expense Benefits	Approved-Closed	Yes

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Note To Filer

Created By:

Rosalind Minor on 06/15/2009 03:02 PM

Last Edited By:

Rosalind Minor

Submitted On:

06/15/2009 03:04 PM

Subject:

TOI

Comments:

I have noted the change in the TOI. There is no need to resubmit.

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Project Name/Number: 9270 VSP Rev. 06-09/9270 VSP Rev. 06-09

Note To Reviewer

Created By:

Janis Landon on 06/11/2009 08:47 AM

Last Edited By:

Rosalind Minor

Submitted On:

06/15/2009 03:04 PM

Subject:

TOI

Comments:

We have just noticed that our submission is coded with a Dental TOI. The TOI should be H20G Group Health - Vision and the Sub-TOI H20G.000 Health - Vision.

We are unable to go into the filing and change the coding. Can you note the change, or would you like us to resubmit?

I apologize for any inconvenience this may cause.

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	9270 VSP Rev. 06-09	Certificate	Eye Care Expense Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: 9270 VSP Rev. 04-06 Previous Filing #: 32351	51	9270 VSP Rev. 06-09.pdf
Approved-Closed	9270 EM Rev. 06-09	Certificate	Eye Care Expense Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: 9270 EM Rev. 04-06 Previous Filing #: 32351	50	9270 EM Rev. 06-09.pdf

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of:

- A. the provider's charge, or
- B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES

Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured [unless otherwise required by state regulation].

EXTENSION OF BENEFITS

We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED

An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS [

This plan has the following limitations.

- 1) This plan does not cover more than one Eye Exam in any 24-month period.
- 2) This plan does not cover more than one pair of Lenses in any 24-month period.
- 3) This plan does not cover more than one pair of Prescription Safety Lenses in any 24-month period.
- 4) This plan does not cover more than one set of Frames in any 24-month period.
- 5) This plan does not cover more than one set of Prescription Safety Frames in any 24-month period.
- 6) This plan does not cover Elective Contact Lenses more than once in any 24-month period. Contact Lenses and associated expenses are in lieu of any other Lenses or Frame benefit.
- 7) This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit. This benefit is in lieu of Elective Contact Lenses.
- 8) This plan does not cover any procedure to change the shape of the cornea in order to reduce Myopia.
- 9) This plan does not cover the refitting of Contact Lenses after the initial 90-day fitting period.
- 10) This plan does not cover Plano Contact Lenses to change eye color.
- 11) This plan does not cover artistically painted Contact Lenses.
- 12) This plan does not cover contact lens insurance policies or service contracts.
- 13) This plan does not cover additional office visits associated with contact lens pathology.
- 14) This plan does not cover contact lens modification, polishing or cleaning.
- 15) This plan does not cover Orthoptics or vision training and any associated testing.
- 16) This plan does not cover Plano Lenses.
- 17) This plan does not cover two pairs of glasses in lieu of Bifocals.
- 18) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
- 19) This plan does not cover medical or surgical treatment of the eyes.
- 20) This plan does not cover services for claims filed more than 180 days after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- 21) This plan does not cover the following materials over and above the Covered Expense for the basic material: blended lenses, oversized lenses, and photochromic or tinted lenses except pink #1 and #2.
- 22) This plan does not cover the coating or laminating of the lens or lenses.
- 23) This plan does not cover corrective vision treatments that are experimental.

- 24) This plan does not cover Corneal Refractive Therapy (CRT).
- 25) This plan does not cover costs for services and/or materials that exceed the Maximum Covered Expense.
- 26) This plan does not cover services or materials that are cosmetic.
- 27) This plan does not cover prescription Safety Eyewear for dependents.
- 28) This plan does not cover Safety Eyewear unless prescribed by the treating provider. The Safety Eyewear must be prescribed due to the nature of the Insured's work.
- 29) This plan does not cover any procedure not listed on the Schedule of Eye Care Services.

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SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

<i>SERVICE</i>	<i>PLAN MAXIMUM COVERED EXPENSE</i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Exam	Covered in Full	Up to \$ [52.00]
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered in Full	Up to \$ [55.00]
Lined Bifocal Lenses	Covered in Full	Up to \$ [75.00]
Lined Trifocal Lenses	Covered in Full	Up to \$ [95.00]
Lenticular Lenses	Covered in Full	Up to \$ [125.00]
Progressive Lenses	Up to an Agreed Amount*	Up to \$ [20.00-300.00]
Frame	\$ [60.00-300.00]	Up to \$ [30.00-300.00]
Contact Lenses**		
Elective	\$ [60.00-300.00]	Up to \$ [30.00-300.00]
Medically Necessary	Covered in Full	Up to \$ [210.00]
Prescription Safety Eyewear		
Safety Eyewear Exam	Covered in Full	Up to \$ [7.00]
Single Vision Lenses	Covered in Full	Up to \$ [55.00]
Lined Bifocal Lenses	Covered in Full	Up to \$ [75.00]
Lined Trifocal Lenses	Covered in Full	Up to \$ [95.00]
Lenticular Lenses	Covered in Full	Up to \$ [125.00]
Frame	Up to \$ [80.00]	Up to \$ [40.00]
A. Prescription Safety Lenses must meet the following conditions:		
1. Be no less than 3 millimeters at the thinnest point		
2. Be impact tested with a one-inch steel ball dropped from a height of 50 inches		
3. Be engraved by the manufacturer that it is a safety lens		
B. Prescription Safety Frames must meet the following conditions:		
1. Have a Z-87 stamp on the front and temples		
2. Be fabricated of a slow burning material		
3. Have manufacturer's logo imprint		
4. Be constructed, so that, if impacted from the front, the lens will not come out through the back of the frame.		

An Insured can receive professional services for treatment of severe visual problems. A treating provider may prescribe Low Vision treatment. This treatment is for problems that are not correctable with regular lenses. The treating provider determines if the Insured meets the criterion for coverage of this benefit.

*We cover Progressive lenses are covered up to the participating provider's contracted fee for [Lined Bifocal] [Lined Trifocal] Lenses. The patient is responsible for the difference between the contracted fee and the Progressive Lenses charge.

**The contact lenses allowance applies to the contact lens exam and lenses.]

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of:

- A. the provider's charge, or
- B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES

Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES.

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured [unless otherwise required by state regulation].

EXTENSION OF BENEFITS

We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED

An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS

This plan has the following limitations.

- [
- 1) This plan does not cover more than one Eye Exam in any 24-month period.
 - 2) This plan does not cover more than one pair of ophthalmic Lenses in any 24-month period.
 - 3) This plan does not cover more than one set of Frames in any 24-month period.
 - 4) This plan does not cover Elective Contact Lenses more than once in any 24-month period. Contact Lenses and associated expenses are in lieu of any other Lenses or Frame benefit.
 - 5) This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.
 - a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
 - b. Patients whose vision can be corrected two lines of improvement on the visual activity chart when compared to best standard spectacle lens correction.
 - c. Anisometropia of 3D or more.
 - d. High Ametropia exceeding -10D or +10D in spherical equivalent.
 - 6) This plan does not cover Orthoptics or vision training and any associated testing.
 - 7) This plan does not cover Plano Lenses.
 - 8) This plan does not cover non-prescribed Lenses or sunglasses.
 - 9) This plan does not cover two pairs of glasses in lieu of Bifocals.
 - 10) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
 - 11) This plan does not cover medical or surgical treatment of the eyes or supporting structures.
 - 12) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
 - 13) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

]

SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

<i>SERVICE</i>	<i>PLAN MAXIMUM COVERED EXPENSE</i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Exam <i>(All lenses are per pair)</i>	Covered in Full	Up to \$[35.00]
Single Vision Lenses	Covered In Full	Up to \$[25.00]
Lined Bifocal Lenses	Covered In Full	Up to \$[40.00]
Lined Trifocal Lenses	Covered In Full	Up to \$[55.00]
Lenticular Lenses	Covered in Full	Up to \$[55.00-80.00]
Frame	Up to \$[60.00-300.00]	Up to \$[30.00-300.00]
Contact Lenses*		
Elective	Up to \$[60.00-300.00]	Up to \$[30.00-300.00]
Medically Necessary	Covered In Full	Up to \$[200.00]
Contact Lens Standard Fit and Follow-Up	Covered in Full	Up to \$[40.00]
Contact Lens Premium Fit and Follow-Up	Up to \$[55.00]	Up to \$[40.00]

*The Contact Lenses allowance applies to the contact lens exam and lenses.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	06/15/2009
Comments:		
Attachments:		
ar-readability-rsl.pdf		
ar-regulation 19-certification-rsl.pdf		
Bypassed -Name: Application	Review Status: Approved-Closed	06/15/2009
Bypass Reason: n/a		
Comments:		
Satisfied -Name: Third Party Authorization	Review Status: Approved-Closed	06/15/2009
Comments:		
Attachment:		
RSL authorization.pdf		
Satisfied -Name: Optionals and Variables	Review Status: Approved-Closed	06/15/2009
Comments:		
Attachment:		
opts-var-9270 rev 06-09 EM_VSP.pdf		

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

INSURER:

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:

FLESCH SCORE:

FORM NAME:

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: _____

TYPED NAME:

TITLE:

DATE: _____

STATE OF ARKANSAS

REGULATION 19

INSURER:

This is to certify that the attached form(s) are in compliance with Rule and Regulation 19:

Form Number:

Form Name:

SIGNATURE:

TYPED NAME:

TITLE:

DATE:

RELIANCE STANDARD

Life Insurance Company

a **DELPHI** company

2001 Market Street, Suite 1500
Philadelphia, PA 19103-7090
(267) 256-3500
(800) 351-7500

January 2009

ALL STATE INSURANCE DEPARTMENT PERSONNEL

Reliance Standard Life Insurance Company, Administrative Offices at 2001 Market Street, Suite 1500 Philadelphia, Pennsylvania 19103, has provided Ameritas Life Insurance Corp. with the authority to submit forms related to dental and vision insurance benefits on our behalf. Accordingly, Ameritas Life Insurance Corp. has the authority to represent us in the submission and negotiation of the approval of these forms and their accompanying rates.

In this regard the signatures of:

Gail M. Garcia
Vice President, Group Compliance

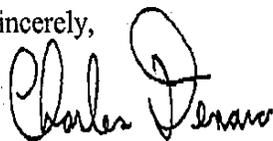
Gary R. Raymond
Vice President — Group Actuary

Janis Landon
Senior Contract Analyst

Kate McCown
Senior Compliance Administrator

when affixed to a letter or certification of intent, will be as binding as if signed by an officer of Reliance Standard Life Insurance Company.

Sincerely,



Charles Denaro
Secretary

**OPTIONALS AND VARIABLES
EYE CARE EXPENSE BENEFIT
FORM: 9270 EM/VSP Rev. 06-09**

- a) The time period in Limitation Nos. 1, 2, 3 or 4 could vary based on our coverage philosophy and/or policyholder negotiation.
- b) Any limitation could be deleted entirely or any of the sub-items based on our coverage philosophy or policyholder negotiation.
- c) The entire lists of procedures are optional and can be removed or modified. The dollar amounts listed are variable and provided for illustrative purposes. The actual dollar amount allowance will be based on the most recent approved rate for each procedure for states that require rate filing and approval.
- d) When a member utilizes a participating provider, the participating provider offers a reduction in the member's out of pocket expenses for specific services, which may or may not be a covered expense as listed in the schedule of eye care services. This reduction is a non-insurance benefit and is provided at no additional cost to the member or the group. A reduction on any service will be outlined on the schedule of eye care services upon a policyholder's request. A member may contact us or their plan administrator for instructions on how to obtain information related to this reduction
- e) The following language will be added when the Contact Lens Fit and Follow-Up benefit is selected by the policyholder:
 - The Standard Contact Lens Fit includes spherical clear contact lenses in conventional wear and planned replacement. Examples include disposable and frequent replacements lenses. The Standard Contact Lens Fit includes two Follow-Up exams.
 - The Premium Contact Lens Fit includes all lens designs, materials and special fittings other than Standard Contact Lenses. Examples include cosmetic color, toric, multi-focal, continuous wear, and RGP lenses.
- f) The following language will be included on plans where the Fit and Follow-Up Exam is not a benefit selected by the policyholder:

The Insured may receive services for Contact Lens Fit and Follow-Up at a reduced cost.