

<i>SERFF Tracking Number:</i>	<i>AMFA-127622669</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Standard Insurance Company</i>	<i>State Tracking Number:</i>	<i>49870</i>
<i>Company Tracking Number:</i>	<i>SIC - 9270 VSP REV. 09-11</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>SIC - 9270 VSP Rev. 09-11</i>		
<i>Project Name/Number:</i>	<i>9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11</i>		

Filing at a Glance

Company: Standard Insurance Company

Product Name: SIC - 9270 VSP Rev. 09-11

TOI: H20G Group Health - Vision

Sub-TOI: H20G.000 Health - Vision

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: AMFA-127622669 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49870

Co Tr Num: SIC - 9270 VSP REV. State Status: Approved-Closed
09-11

Reviewer(s): Rosalind Minor

Authors: Janis Landon, Stephanie
Disposition Date: 09/27/2011

Mundt, Mary Chmelka

Date Submitted: 09/26/2011

Disposition Status: Approved-
Closed

Implementation Date:

General Information

Project Name: 9270 VSP Rev. 09-11

Project Number: 9270 VSP Rev. 09-11

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 09/27/2011

State Status Changed: 09/27/2011

Created By: Janis Landon

Corresponding Filing Tracking Number:

Filing Description:

Form No.: 9270 VSP Rev. 09-11 - Eye Care Expense Benefits insert page (Provider Network - Vision Service Plan, Inc)
9040 Rev. 09-11 – Schedule of Benefits

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Mary Chmelka

PLEASE NOTE: This filing is identical in content to two other filings being submitted on behalf of Reliance Standard Life Insurance Company and Ameritas Life Insurance Company. We would appreciate the Department's consideration of consistent and similar reviews.

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Dear Sir/Madam:

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 under SERFF # AMFA-125485831 and will replace previously approved forms 9270 VSP Rev. 06-09 (SERFF #AMFA-126177338) and 9040 Rev. 07-11 (SERFF #AMFA-127322789).

The 9270 VSP Rev. 09-11 form provides Eye Care Expense Benefits in which the reimbursement for covered services is based on a scheduled amount. The reimbursement amount varies whether the covered person seeks services from a participating or non-participating provider. However, the covered person has the freedom of choice to visit any provider at any time.

The 9040 Rev. 09-11 has been revised to reflect the Contact Lens Fitting and Evaluation deductible.

These forms will be marketed to any eligible group as defined by the state of issue however; the primary market will be an employer-employee group. Forms are in final print. The items shown in brackets represent variable material. These items would vary based on the specific plan(s) as selected by the policyholder. An Optional and Variables statement is also included for your reference.

If your state requires the filing of group rates, please be advised that rates associated with this form have been submitted under separate cover.

Form 9040 Rev. 09-11 achieved a 50 and 9270 VSP Rev. 09-11 achieved a 51 on the Flesch Readability Scale, when scored with the policy and certificate.

Nothing in this filing includes any provisions contrary to standard industry practice.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,
Janis Landon
Sr. Contact Analyst

Company and Contact

Filing Contact Information

SERFF Tracking Number: AMFA-127622669 State: Arkansas
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 Project Name/Number: 9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11

Janis Landon, Senior Contract Analyst jlandon@ameritas.com
 475 Fallbrook Blvd. 800-745-1112 [Phone] 82444 [Ext]
 Lincoln, NE 68521 402-309-2573 [FAX]

Filing Company Information

Standard Insurance Company	CoCode: 69019	State of Domicile: Oregon
900 SW Fifth Avenue	Group Code: 1348	Company Type:
Portland, OR 97204-1235	Group Name:	State ID Number:
(800) 745-6665 ext. [Phone]	FEIN Number: 93-0242990	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	2 forms x \$50 per forms = \$100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$100.00	09/26/2011	52120810

<i>SERFF Tracking Number:</i>	<i>AMFA-127622669</i>	<i>State:</i>	<i>Arkansas</i>
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/27/2011	09/27/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	EYE CARE EXPENSE BENEFITS	Mary Chmelka	09/26/2011	09/26/2011
Supporting Document	Redline Versions	Mary Chmelka	09/26/2011	09/26/2011

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<i>Project Name/Number:</i>	<i>9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11</i>		

Disposition

Disposition Date: 09/27/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document (revised)	Redline Versions	Approved-Closed	Yes
Supporting Document	Redline Versions	Replaced	Yes
Supporting Document	Optionals & Variables	Approved-Closed	Yes
Form	SCHEDULE OF BENEFITS	Approved-Closed	Yes
Form (revised)	EYE CARE EXPENSE BENEFITS	Approved-Closed	Yes
Form	EYE CARE EXPENSE BENEFITS	Replaced	Yes

SERFF Tracking Number: AMFA-127622669 State: Arkansas
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 Project Name/Number: 9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11

Amendment Letter

Submitted Date: 09/26/2011

Comments:

We have attached a new Eye Care Expense Benefits form and a new redline version of the same form.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
9270 VSP Rev. 09-11	Policy/Contract	EYE CARE EXPENSE BENEFITS Certificate: AMENDMENT, Insert Page, Endorsement or Rider	Revised		AMFA-126177338	9270 VSP Rev. 06-09	50.000	9270 VSP Rev 09-11.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Redline Versions

Comment:

9040 Rev. 09-11-rl.pdf
 9270 VSP Rev 09-11-rl clean.pdf

SERFF Tracking Number: AMFA-127622669 State: Arkansas
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 Project Name/Number: 9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11

Form Schedule

Lead Form Number: 9270 VSP Rev. 09-11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/27/2011	9040 Rev. 09-11	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	SCHEDULE OF BENEFITS	Revised	Replaced Form #: 9040 Rev. 07-11 Previous Filing #: AMFA-127322789	50.000	9040 Rev. 09-11.pdf
Approved-Closed 09/27/2011	9270 VSP Rev. 09-11	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	EYE CARE EXPENSE BENEFITS	Revised	Replaced Form #: 9270 VSP Rev. 06-09 Previous Filing #: AMFA-126177338	50.000	9270 VSP Rev 09-11.pdf

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured [and each Insured Dependent] will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
[Class 1	All Eligible Employees]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[When a Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

[When a Non-Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

Maximum Deductible [each Benefit Period, per Quarter] [\$50]

[[Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible.] Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.]

[Dental expenses incurred by an individual on or after January 1, [2010], but before [May 1, 2010], will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to [May 1, 2010]; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.]

Coinsurance Percentage:	[Participating Provider]	[Non-Participating Provider]
[Type 1 Procedures]	[100%]	[90%]
[Type 2 Procedures]	[80%]	[70%]
[Type 3 Procedures]	[50%]	[40%]
[Type 4 Procedures]	[50%]	[50%]

Maximum Amount – [Each Benefit Period] [\$1500][*]

SCHEDULE OF BENEFITS

(Continued)

[You and/or your dependents must be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[ORTHODONTIC EXPENSE BENEFITS

[Deductible Amount]	[\$0]
[Coinsurance Percentage]	[50%]
[Maximum Benefit during Lifetime]	[\$1,000]

[The Plan pays [25%-50%] of covered Orthodontic Expenses.]

[The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
- b. on [January 1, 2008] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

[You and/or your dependents must be insured under the dental plan for [12] months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[EYE CARE EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[Exam- [each Benefit Period]]	[\$ 10][*]
[Contact Lens Fitting and Evaluation][each Benefit Period]	[\$0-60]
[Lenses - Other than contact lenses- [Once Per Lifetime]]	[\$ 25][*]
[Frames and Contact Lenses - [Once Per Lifetime]]	[\$ 25][*]

[Maximum Amount – [each Benefit Period] [\$200][*]

[Increasing Eye Care Maximum

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount -	1st Benefit Period	[\$0-350]
	2nd Benefit Period	[\$0-350]
	3rd Benefit Period	[\$50-400]
	4th + Benefit Period	[\$50-400]]

[Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.]

[LASER VISION CORRECTION EXPENSE BENEFITS

[Deductible Amount - [each Benefit Period]]	[\$50]
Coinsurance Percentage:	[100%]

[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]

[HEARING CARE EXPENSE BENEFITS

Deductible Amount:

[Exams] - [each Benefit Period]	[\$0]
[Hearing Aids] - [each Benefit Period]	[\$0]
[Hearing Aid Maintenance] - [each Benefit Period]	[\$0]
[Hearing Miscellaneous] - [each Benefit Period]	[\$0]]

[If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

[Exams]	[100%*]
[Hearing Aids]	[50%]
[Hearing Aid Maintenance]	[100%*]
[Hearing Miscellaneous]	[100%*]]

*refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

[1st 12 month Period]	[\$400]
[2nd 12 month Period]	[\$600]
[3rd 12 month Period]	[\$800]
[4th 12 month Period or thereafter]	[\$1,000]

The term "12 Month Period" means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy **BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION.** For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[COMBINED EXPENSE BENEFITS

[*Combined [Dental And Eye Care] Deductible Amount: [each Benefit Period]] [\$50]
The deductibles listed with the () above are subject to the maximum deductible amount listed here.]*

[*Combined [Dental and Eye Care] Maximum – [each Benefit Period] [\$1,500]
The maximums listed with the () above are subject to the maximum amount listed here.]*

[Combined [Dental and Eye Care] Exam Frequencies
Routine Exams for [Dental and Eye Care] are limited to [Twice] per [Benefit Period]

Dental Exams will include:

- [D0120 Periodic oral evaluation]
- [D0150 Comprehensive oral evaluation - new or established patient.]
- [D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine eye care exam is a vision examination as defined on the Schedule of Eye Care Services.]

The above frequencies for [Dental and Eye Care] Exams are subject to the plan frequencies as defined within the [Table of Dental Procedures and the Eye Care Insurance provision].]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

- First Level: The Plan pays [0 - 100]% of the first \$[0-5,000] of Covered [Preventive, Dental and Orthodontic] Expenses [up to the Maximum Amount].
- Second Level: You pay the next \$[25 - 250] of Covered Expenses. (You will not be reimbursed for this \$[25 - 250] of Covered Expenses.)
- Third Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental

and Orthodontic] Expenses [subject to the Maximum Amount].

Fourth Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

Fifth Level: The Plan will also pay [0 - 100]% of the remaining \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount [per Benefit Period]

[\$500 - 2,500, Not Applicable]]

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

[We are committed to your satisfaction. If your new plan has a benefit that is similar to the benefit provided under your preceding plan and the lenses and frames you received were the same as those covered under your preceding plan, VSP will, upon your request, assist you with any transitional issues relating to these lenses and frames you may experience during the first year of your VSP coverage. Contact VSP Member Services at 800.877.7195 for more details.]

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services below.

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 PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. [Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195].

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 may be 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 [arranged differently through an Affiliate or Open Access provider, or] otherwise required by state regulation.

EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED

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

PROOF OF LOSS

Written proof of loss must be given to us within [180] days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

[LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.]

[EXCLUSIONS

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay,
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.]

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		Participating Provider	Non-Participating Provider[*]
[Vision Examination(s)]			
[Eye Exam]	[Once] every [XX] [months]	Covered in Full	Up to \$ [52.00]
[Retinal Screening]	[Once] every [XX] [months]	Covered in Full	[See Eye Exam benefit above]
[Contact Lens Fitting & Evaluation]	[Once] every [XX] [months]	[Covered in Full] [See Elective Contact Lenses benefit below]	[See Elective Contact Lenses benefit below]
[Prescription Safety Eyewear]	[Once] every [XX] [months]	Covered in Full	Up to \$ [8.00]
[Complete Pair of Spectacles]			
[Lenses (per pair, only one pair of lens type below allowed per covered period) [includes Safety Eyewear]			
[Single Vision]	[Once] every [XX] [months]	Covered in Full	Up to \$ [55.00]
[Lined Bifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [75.00]
[Lined Trifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [95.00]
[Lenticular]	[Once] every [XX] [months]	Covered in Full	Up to \$ [125.00]
[Progressive]	[Once] every [XX] [months]	Up to an Agreed Amount [#]	Up to \$ [20.00 – 300.00]
[Frames]			
[Single Frame][%]	[Once] every [XX] [months]	Up to \$ [40.00 – 300.00]	Up to \$ [30.00 – 300.00]
[Safety Eyewear Frame^]	[Once] every [XX] [months]	Up to \$ [80.00]	Up to \$ [40.00]
[Contact Lenses (in lieu of Complete Pair of Spectacles) [Includes allowance for Contact Len Fitting & Evaluation]			
[Elective]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Medically Necessary]	[Once] every [XX] [months]	Covered in Full	Up to \$ [210.00]

[Low Vision (for sever visual problems not correctable with regular lenses, as determined by the treating provider)
Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.]

[*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider]

[#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 base lens and the Progressive Lenses charge.]

[%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.]

[^Lenses prescribed for safety eyewear must be no less than 3 millimeters at the thinnest point, impact tested with a one-inch steel ball dropped from a height of 50 inches, and engraved by the manufacturer that it is a safety lens.]

[^Frames prescribed for safety eyewear must have a Z-87 stamp on the front and temples, be fabricated of a slow burning material, have a manufacturer's logo imprint, and be constructed so that, if impacted from the front, the lens will not come out through the back of the frame]

[SUPPLEMENTAL EYE CARE BENEFIT

This rider lists additional eye care care benefits to which Insureds are entitled, subject to any applicable Deductible Amount and other conditions, limitations and/or exclusions stated herein. Benefits under the Supplemental Eye Care Benefit Rider are available to Insureds only after applicable benefits under their group medical plan have been exhausted, or when the Insured is not covered under a group medical plan. This rider forms a part of the Policy and Evidence of Coverage to which it is attached.

This rider is designed to cover procedures related to the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Eye care professionals provide treatment and management of urgent and follow-up services, including management of conditions which require monitoring to prevent future vision loss.

The eye care professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the eye care professional to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

There is no coverage provided under this rider for the following:

1. Costs associated with securing frames, lenses or any other materials.
2. Orthoptics or vision training and any associated supplemental testing.
3. Laser or any other form of refractive surgery or procedure.
4. Pathological treatment.
5. Any eye examination required by an employer as a condition of employment.
6. Medication.
7. Pre- and post-operative services.
8. Services and/or materials not indicated on this rider as Covered Services.

COVERED SERVICES

SERVICE CATEGORY	CONTRACTING PROVIDER BENEFIT	NON-CONTRACTING PROVIDER BENEFIT (Plan Pays)
CATEGORY A Services	Covered in full after \$ [5.00-50.00] Deductible per visit	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable
CATEGORY B Services	Covered in full	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable

COVERED SERVICES by CATEGORY

PROCEDURE CODE	DESCRIPTION
CATEGORY A Services	
92002, 92004, 92012, 92014, 92070*	Ophthalmological services
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	Office Visits
99050, 99051	Afterhours services; additional services
99241, 99242, 99243, 99244, 99245	Office consultations
CATEGORY B Services	
92020*, 92025*	Gonioscopy
92081, 92082, 92083	Visual field exams
92100*	Serial tonometry
92120	Tonography with interpretation and report
92130	Tonography with water provocation
92140	Provocative tests for glaucoma
92225, 92226*	Extended Ophthalmoscopy

COVERED SERVICES by CATEGORY (cont.)

Procedure Code	Description
92250	Fundus Photography
92260	Ophthalmodynamometry
92270	Electro-oculography with interpretation and report
92275	Electroretinography with interpretation and report
92283	Color vision exam, extended
92284	Dark adaptation exam with interpretation and report
92285*	External ocular photography
92286*	Special anterior segment photography
92287*	Special anterior segment photography with fluorescein angiography
95930	Visual evoked potential (VEP) testing central nervous system
65205, 65210, 65220, 65222	Removal, foreign body, external eye
65430	Scraping of cornea
65435	Removal of corneal epithelium
67820	Correction of trichiasis
67938	Removal of embedded foreign body, eyelid
68761*	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum
68810, 68815*	Probing of nasolacrimal duct
76514*	Corneal pachymetry, unilateral or bilateral

*Service and/or diagnosis limitations apply or procedure requires special handling. VSP Network Doctors must contact VSP for details before rendering services.]

<i>SERFF Tracking Number:</i>	<i>AMFA-127622669</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Standard Insurance Company</i>	<i>State Tracking Number:</i>	<i>49870</i>
<i>Company Tracking Number:</i>	<i>SIC - 9270 VSP REV. 09-11</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>SIC - 9270 VSP Rev. 09-11</i>		
<i>Project Name/Number:</i>	<i>9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: ar-readability-sic.pdf	Approved-Closed	09/27/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: n/a Comments:	Approved-Closed	09/27/2011

	Item Status:	Status Date:
Satisfied - Item: 3rd Party Authorization Comments: Attachment: SIC authorization 01-2011.pdf	Approved-Closed	09/27/2011

	Item Status:	Status Date:
Satisfied - Item: Redline Versions Comments: Attachments: 9040 Rev. 09-11-rl.pdf 9270 VSP Rev 09-11-rl clean.pdf	Approved-Closed	09/27/2011

	Item Status:	Status Date:
Satisfied - Item: Optionals & Variables Comments:	Approved-Closed	09/27/2011

SERFF Tracking Number: AMFA-127622669 *State:* Arkansas
Filing Company: Standard Insurance Company *State Tracking Number:* 49870
Company Tracking Number: SIC - 9270 VSP REV. 09-11
TOI: H20G Group Health - Vision *Sub-TOI:* H20G.000 Health - Vision
Product Name: SIC - 9270 VSP Rev. 09-11
Project Name/Number: 9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11

Attachments:

opts-var-9270 rev 09-11 VSP only.pdf
Opt & Var 9040 Rev. 09-11.pdf

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

INSURER: Standard Insurance Company

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

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
9040 Rev. 09-11	50, with policy/certificate	Schedule of Benefits
9270 VSP Rev. 09-11	50	Eye Care Expense Benefits

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: **Gail M. Garcia**
TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance
DATE: 9/20/11

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life
Insurance Corp., ou=Group
Compliance, email=ggarcia@ameritas.
com, c=US
Date: 2010.09.01 12:41:24 -05'00'



January 2011

TO ALL STATE INSURANCE DEPARTMENT PERSONNEL

Standard Insurance Company, Administrative Offices at 1100 SW Sixth Avenue, Portland, Oregon 97204-1093, 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

Kelly Wieseler
Vice President, Group Actuary

Janis Landon
Senior Contract Analyst

Kate McCown
Manager, Group Compliance

Geri L. McKeown
Manager, Group Compliance

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

Sincerely,

A handwritten signature in black ink, appearing to read "Alex M Terry".

Alex Terry, FSA, MAAA
Second Vice President and Associate Actuary
900 SW Fifth Avenue
Portland OR 97204-1235
971.321.8232

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured [and each Insured Dependent] will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
[Class 1	All Eligible Employees]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[When a Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

[When a Non-Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[\$0][*]
[Type 2 Procedures] - [each Benefit Period]	[\$50][*]
[Type 3 Procedures] - [each Benefit Period]	[\$50][*]
[Type 4 Procedures] - [each Benefit Period]	[\$50][*]

Maximum Deductible [each Benefit Period, per Quarter] [\$50]

[[Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible.] Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.]

[Dental expenses incurred by an individual on or after January 1, [2010], but before [May 1, 2010], will apply to the Deductible Amount if:

- a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to [May 1, 2010]; and
- b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.]

Coinsurance Percentage:	[Participating Provider]	[Non-Participating Provider]
[Type 1 Procedures]	[100%]	[90%]
[Type 2 Procedures]	[80%]	[70%]
[Type 3 Procedures]	[50%]	[40%]
[Type 4 Procedures]	[50%]	[50%]

Maximum Amount – [Each Benefit Period] [\$1500][*]

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SCHEDULE OF BENEFITS

(Continued)

[You and/or your dependents must be insured under the dental plan for [6] months to be eligible for Type [3] Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[ORTHODONTIC EXPENSE BENEFITS

[Deductible Amount]	[\$0]
[Coinsurance Percentage]	[50%]
[Maximum Benefit during Lifetime]	[\$1,000]

[The Plan pays [25%-50%] of covered Orthodontic Expenses.]

[The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
- b. on [January 1, 2008] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

[You and/or your dependents must be insured under the dental plan for [12] months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]

[EYE CARE EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[Exam- [each Benefit Period]]	[\$ 10][*]
[Contact Lens Fitting and Evaluation][each Benefit Period]	[\$0-60]
[Lenses - Other than contact lenses- [Once Per Lifetime]]	[\$ 25][*]
[Frames and Contact Lenses - [Once Per Lifetime]]	[\$ 25][*]

[Maximum Amount – [each Benefit Period] [\$200][*]

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[Increasing Eye Care Maximum

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount -	1st Benefit Period	[\$0-350]
	2nd Benefit Period	[\$0-350]
	3rd Benefit Period	[\$50-400]
	4th + Benefit Period	[\$50-400]]

[Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.]

[LASER VISION CORRECTION EXPENSE BENEFITS

[Deductible Amount - [each Benefit Period]]	[\$50]
Coinsurance Percentage:	[100%]

[Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.]

[HEARING CARE EXPENSE BENEFITS

Deductible Amount:

[Exams] - [each Benefit Period]	[\$0]
[Hearing Aids] - [each Benefit Period]	[\$0]
[Hearing Aid Maintenance] - [each Benefit Period]	[\$0]
[Hearing Miscellaneous] - [each Benefit Period]	[\$0]]

[If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

[Exams]	[100%*]
[Hearing Aids]	[50%]
[Hearing Aid Maintenance]	[100%*]
[Hearing Miscellaneous]	[100%*]]

*refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:

[1st 12 month Period]	[\$400]
[2nd 12 month Period]	[\$600]
[3rd 12 month Period]	[\$800]
[4th 12 month Period or thereafter]	[\$1,000]

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The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured’s initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured’s new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy **BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION**. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[COMBINED EXPENSE BENEFITS

[*Combined [Dental And Eye Care] Deductible Amount: [each Benefit Period]] [\$50]
The deductibles listed with the () above are subject to the maximum deductible amount listed here.]*

[*Combined [Dental and Eye Care] Maximum – [each Benefit Period] [\$1,500]
The maximums listed with the () above are subject to the maximum amount listed here.]*

[Combined [Dental and Eye Care] Exam Frequencies
Routine Exams for [Dental and Eye Care] are limited to [Twice] per [Benefit Period]

Dental Exams will include:

- [D0120 Periodic oral evaluation]
- [D0150 Comprehensive oral evaluation - new or established patient.]
- [D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine eye care exam is a vision examination as defined on the Schedule of Eye Care Services.]

The above frequencies for [Dental and Eye Care] Exams are subject to the plan frequencies as defined within the [Table of Dental Procedures and the Eye Care Insurance provision].]

[DENTAL EXPENSE BENEFITS

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

- First Level: The Plan pays [0 - 100]% of the first \$[0-5,000] of Covered [Preventive, Dental and Orthodontic] Expenses [up to the Maximum Amount].

- Second Level: You pay the next \$[25 - 250] of Covered Expenses. (You will not be reimbursed for this \$[25 - 250] of Covered Expenses.)

- Third Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental

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and Orthodontic] Expenses [subject to the Maximum Amount].

Fourth Level: The Plan will also pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

Fifth Level: The Plan will also pay [0 - 100]% of the remaining \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount [per Benefit Period]

[\$500 - 2,500, Not Applicable]

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EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured ~~can choose any provider at any time.~~

Deleted: may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to

~~[We are committed to your satisfaction. If your new plan has a benefit that is similar to the benefit provided under your preceding plan and the lenses and frames you received were the same as those covered under your preceding plan, VSP will, upon your request, assist you with any transitional issues relating to these lenses and frames you may experience during the first year of your VSP coverage. Contact VSP Member Services at 800.877.7195 for more details.]~~

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AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services ~~below.~~

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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 PROVIDERS

A Participating Provider ~~is a provider who has agreed to participate in the VSP network and~~ agrees to provide services and supplies to the Insured at a discounted fee. ~~For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.~~

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. ~~[Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.]~~

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 ~~may be~~ limited to those for a Non-Participating Provider.

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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 [arranged differently through an Affiliate or Open Access provider, or]~~ otherwise required by state regulation.

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EXTENSION OF BENEFITS

~~If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.~~

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EXPENSES INCURRED

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

PROOF OF LOSS

Written proof of loss must be given to us within [180] days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below.
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses.
- Two pairs of glasses in lieu of Bifocals.
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

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SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section. You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		Participating Provider	Non-Participating Provider[*]
[Vision Examination(s)]			
[Eye Exam]	[Once] every [XX] [months]	Covered in Full	Up to \$ [52.00]
[Retinal Screening]	[Once] every [XX] [months]	Covered in Full	[See Eye Exam benefit above]
[Contact Lens Fitting & Evaluation]	[Once] every [XX] [months]	[Covered in Full]	[See Elective Contact Lenses benefit below]
[Prescription Safety Eyewear]	[Once] every [XX] [months]	Covered in Full	Up to \$ [8.00]

[Complete Pair of Spectacles]

[Lenses (per pair, only one pair of lens type below allowed per covered period) [includes Safety Eyewear]

[Single Vision]	[Once] every [XX] [months]	Covered in Full	Up to \$ [55.00]
[Lined Bifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [75.00]
[Lined Trifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [95.00]
[Lenticular]	[Once] every [XX] [months]	Covered in Full	Up to \$ [125.00]
[Progressive]	[Once] every [XX] [months]	Up to an Agreed Amount [#]	Up to \$ [20.00 - 300.00]

[Frames]

[Single Frame][%]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Safety Eyewear Frame^]	[Once] every [XX] [months]	Up to \$ [80.00]	Up to \$ [40.00]

[Contact Lenses (in lieu of Complete Pair of Spectacles) [Includes allowance for Contact Len Fitting & Evaluation]

[Elective]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Medically Necessary]	[Once] every [XX] [months]	Covered in Full	Up to \$ [210.00]

[Low Vision (for sever visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.]

[*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider]

[#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 base lens and the Progressive Lenses charge.]

[%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.]

- Deleted: ¶ 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.¶ ... [13]
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[^Lenses prescribed for safety eyewear must be no less than 3 millimeters at the thinnest point, impact tested with a one-inch steel ball dropped from a height of 50 inches, and engraved by the manufacturer that it is a safety lens.]

[^Frames prescribed for safety eyewear must have a Z-87 stamp on the front and temples, be fabricated of a slow burning material, have a manufacturer's logo imprint, and be constructed so that, if impacted from the front, the lens will not come out through the back of the frame]

[SUPPLEMENTAL EYE CARE BENEFIT

This rider lists additional eye care care benefits to which Insureds are entitled, subject to any applicable Deductible Amount and other conditions, limitations and/or exclusions stated herein. Benefits under the Supplemental Eye Care Benefit Rider are available to Insureds only after applicable benefits under their group medical plan have been exhausted, or when the Insured is not covered under a group medical plan. This rider forms a part of the Policy and Evidence of Coverage to which it is attached.

This rider is designed to cover procedures related to the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Eye care professionals provide treatment and management of urgent and follow-up services, including management of conditions which require monitoring to prevent future vision loss.

The eye care professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the eye care professional to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

There is no coverage provided under this rider for the following:

1. Costs associated with securing frames, lenses or any other materials.
2. Orthoptics or vision training and any associated supplemental testing.
3. Laser or any other form of refractive surgery or procedure.
4. Pathological treatment.
5. Any eye examination required by an employer as a condition of employment.
6. Medication.
7. Pre- and post-operative services.
8. Services and/or materials not indicated on this rider as Covered Services.

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 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]¶
 <#>Prescription Safety Lenses must meet
 the following conditions:¶
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 must meet the following conditions:¶
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COVERED SERVICES

<u>SERVICE CATEGORY</u>	<u>CONTRACTING PROVIDER BENEFIT</u>	<u>NON-CONTRACTING PROVIDER BENEFIT (Plan Pays)</u>
<u>CATEGORY A Services</u>	Covered in full after \$ [5.00-50.00] Deductible per visit	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable
<u>CATEGORY B Services</u>	Covered in full	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable

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COVERED SERVICES by CATEGORY

<u>PROCEDURE CODE</u>	<u>DESCRIPTION</u>
<u>CATEGORY A Services</u>	
<u>92002, 92004, 92012, 92014, 92070*</u>	<u>Ophthalmological services</u>
<u>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</u>	<u>Office Visits</u>
<u>99050, 99051</u>	<u>Afterhours services; additional services</u>
<u>99241, 99242, 99243, 99244, 99245</u>	<u>Office consultations</u>
<u>CATEGORY B Services</u>	
<u>92020*, 92025*</u>	<u>Gonioscopy</u>
<u>92081, 92082, 92083</u>	<u>Visual field exams</u>
<u>92100*</u>	<u>Serial tonometry</u>
<u>92120</u>	<u>Tonography with interpretation and report</u>
<u>92130</u>	<u>Tonography with water provocation</u>
<u>92140</u>	<u>Provocative tests for glaucoma</u>
<u>92225, 92226*</u>	<u>Extended Ophthalmoscopy</u>

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COVERED SERVICES by CATEGORY (cont.)

Procedure Code	Description
92250	Fundus Photography
92260	Ophthalmodynamometry
92270	Electro-oculography with interpretation and report
92275	Electroretinography with interpretation and report
92283	Color vision exam, extended
92284	Dark adaptation exam with interpretation and report
92285*	External ocular photography
92286*	Special anterior segment photography
92287*	Special anterior segment photography with fluorescein angiography
95930	Visual evoked potential (VEP) testing central nervous system
65205, 65210, 65220, 65222	Removal, foreign body, external eye
65430	Scraping of cornea
65435	Removal of corneal epithelium
67820	Correction of trichiasis
67938	Removal of embedded foreign body, eyelid
68761*	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum
68810, 68815*	Probing of nasolacrimal duct
76514*	Corneal pachymetry, unilateral or bilateral

*Service and/or diagnosis limitations apply or procedure requires special handling. VSP Network Doctors must contact VSP for details before rendering services.]

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 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. ¶

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

¶
 ** 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.

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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.		
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7) This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period.		
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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		
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refitting of Contact Lenses after the initial 90-day fitting period,		
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10) This plan does not cover Plano		
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Lenses to change eye color.		
11) This plan does not cover artistically painted Contact Lenses.		
12) This plan does not cover contact lens		
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insurance policies or service contracts,		
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13) This plan does not cover additional		
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14) This plan does not cover contact lens modification, polishing or cleaning.		
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15) This plan does not cover Orthoptics or vision training and any associated testing.		
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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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. No benefits are payable for a service not listed.

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SERVICE

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(All lenses are per pair)
Single Vision Lenses

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Up to \$ [55.00

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Lined Bifocal

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Lined Trifocal Lenses

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Lenticular Lenses

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Progressive Lenses	Up to an Agreed Amount**	Up to \$ [20.00-300.00]
Frame	\$ Up to [60.00-300.00]	Up to \$ [30.00-300.00]

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**OPTIONALS AND VARIABLES
EYE CARE EXPENSE BENEFIT
FORM: 9270 VSP Rev. 09-11**

- a) For existing clients switching from one vision plan to another, the bracketed language regarding transitional assistance will be included.
- b) The "When Covered" time period in the "Schedule of Eye Care Services" could vary based on our coverage philosophy and/or policyholder negotiation.
- c) Any limitation or exclusion could be deleted entirely or any of the sub-items based on our coverage philosophy or policyholder negotiation.
- d) The entire lists of procedures on the "Schedule of Eye Care Services" 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.
- e) If the policyholder elects to offer the VSP Affiliate Provider program, the bracketed language in the "Eye Care Expense Benefits" definition will be included.
- f) The "Supplemental Eye Care Benefit" is a benefit option that will be included on group VSP vision plans if elected by the policyholder. It provides for benefits for additional vision services.

OPTIONALS AND VARIABLES
9040 Rev. 09-11

No change will be made to any policy or certificate in violation of state statutes.

General Items

- 1) We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.
- 2) If the Policyholder has elected multiple plan designs which may be offered within the same policy, e.g., different plans per classes of insureds, optional buy-up feature, tec., then the group policy will be issued with multiple Schedule of Benefits (9040), Dental Expense Benefits (9219) and Table of Dental Procedures (9232) which will reflect each plan design being offered. Each certificate will include only those pages reflecting that plan design.
- 3) If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.
- 4) References to Dental, Eye Care and/or Hearing will be added/removed if the plan design does not contain Dental, Eye Care, and/or Hearing as selected by the Policyholder.
- 5) References to Employer and Employee and the subsequent sections that pertain to an Employer/Employee relationship under the policy may be removed if issued to a policy that is not sponsored by an employer.

SCHEDULE OF BENEFITS – 9040

The Benefit Class Description of eligible members and dependents could be modified as required by the policyholder.

The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances, which are based on the plan design selected by the Policyholder. The Schedule of Benefits will reflect the plan design chosen by the Policyholder.

If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

BENEFIT CLASS & OPTIONS

1. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.
2. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder. (ex. Union employees, non-union employees, clerical employees, non-clerical employees).

DENTAL EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

DEDUCTIBLE AMOUNT

Dependent upon Policyholder selection, Deductible Amounts can range from \$0 to \$250 in increments of \$5, by frequency of services and/or Benefit Type, and can be applied per Benefit Period, Quarter, Visit, and/or Lifetime. Deductible Amounts can be combined to apply to more than one Benefit Type. For example, a \$50 per Benefit Period deductible can apply to Type 1, Type 2, Type 3, and/or Type 4 benefits.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed similar to the following:

Deductible Amount:

When a Participating Provider is used:

Combined Type 1, 2 and Type 3 Procedures - each Benefit Period
\$50

When a Non-Participating Provider is used:

Type 1 Procedures
\$0
Combined Type 2 and Type 3 Procedures - each Benefit Period
\$50

The Maximum Deductible option provides a limit on the Deductible amounts that apply in a Benefit Period. For example, a \$10 per Visit Deductible when seeing a Participating Provider and a \$50 per Benefit Period Deductible when seeing a Non-Participating Provider may be limited to a total of \$50 per Benefit Period deductible when a Participating and Non-Participating Provider are seen in the same Benefit Period. The following language would be added for plans with this option:

Maximum Deductible per Benefit Period
\$50

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.

When the policyholder has chosen to include a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

When the policyholder has chosen to include a maximum on the number of Deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:

On the date that [two] [three] [four] members of one family have satisfied their own Deductible Amounts for [the Benefit Period] [their Lifetime], no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period]. No Covered Expense that was incurred prior to such date that was used to satisfy any part of a Deductible Amount will be eligible for reimbursement, however.

When the policyholder has chosen to include a maximum dollar amount of deductible required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. This dollar amount may be per Benefit Period, Quarter, or Lifetime and ranges from \$0 - \$300 in \$5 increments.

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Maximum Family Deductible
 \$[150]

When the policyholder has chosen to include a maximum dollar amount of Deductible required to be satisfied by a family with different amounts when choosing a Participating versus Non-Participating Provider, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. The dollar amounts may be by Benefit Period, Quarter, or per Lifetime and range from \$0 - \$300 in \$5 increments:

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Provider	Participating Provider	Non-Participating
Maximum Family Deductible	\$[100]	\$[150]

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

COINSURANCE PERCENTAGE

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

Type 1 Procedures	25% - 100%
Type 2, 3, or 4 Procedures	0% - 100%

If the Plan Allowance selected by the policyholder is on a scheduled basis or is based solely on the Actual Charge of the provider the following is included next to the Coinsurance Percentage for clarification purposes:

Coinsurance Percentage:	
Type 1 Procedures Charges]	25% - 100% [of Schedule, of Actual
Type 2 Procedures Charges]	0% - 100% [of Schedule, of Actual
Type 3 Procedures Charges]	0% - 100% [of Schedule, of Actual

Type 4 Procedures
Charges]

0% - 100% [of Schedule, of Actual

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

Coinsurance Percentage: Provider	Participating Provider	Non-Participating
[Type 1 Procedures]	[25% - 100%]	[25% - 100%]
[Type 2 Procedures]	[0% - 100%]	[0% - 100%]
[Type 3 Procedures]	[0% - 100%]	[0% - 100%]
[Type 4 Procedures]	[0% - 100]	[0% - 100%]

The difference between participating and non-participating providers will not exceed state allowances.

If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider amounts, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:

Type 1 Procedures:

Step 1.	70%
Step 2.	80%
Step 3.	90%
Step 4.	100%

Type 2 Procedures:

Step 1.	50%
Step 2.	60%
Step 3.	80%
Step 4.	90%

Type 3 and Type 4 Procedures:

Step 1.	25%
Step 2.	35%
Step 3.	50%
Step 4.	60%

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. The dates used below are illustrative, the appropriate dates based on the policyholder's actual effective date will be used. Below are the Incentive Method descriptive paragraph options that can be selected:

1. Effective Date Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

2. Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].
2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will revert to Step 1 on January 1, [2011]
3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a

dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

3. Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

4. New Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.
2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] who does not visit a dentist during [2009] will remain at the same Step that applied during [2009].
2. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

5. Family Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period.

or

Step 1 applies during the first Benefit Period.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period.

Step 3 will apply during the third Benefit Period.

Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

6. 10% Advance Incentive:

[For those persons insured on <MDY(cDivEffDate)> Step <nDenStart> applies during the first Benefit Period the person becomes insured.

For those persons insured after <MDY(cDivEffDate)> Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, the coinsurance percentage drops back one Step. The coinsurance percentage will never be less than the coinsurance percentage in Step 1.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

7. Date of Hire progressive Incentive:

- A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:
1. Step 1 applies during the first Benefit Period the person becomes insured.
 2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.
 3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the person will remain at the same Step that applied during the previous Benefit Period.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

- B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].
2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will remain at the same Step that applied during the previous Benefit Period.
3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will remain at the same Step that applied during the previous Benefit Period.

8. Date of Hire Advance Incentive:

- A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:
1. Step 1 applies during the first Benefit Period the person becomes insured.
 2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the insured person's coinsurance level will drop back one coinsurance level step.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

- B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

- Step 1 Those employed in [2009]
- Step 2 Those employed in [2008]
- Step 3 Those employed in [2007]
- Step 4 Those employed prior to [2007]

1. Any such person insured between [January 1, 2009], and [December 31, 2009] will advance one step to the next higher Coinsurance Percentage Step on [January 1, 2010], if they have visited a dentist and had a dental procedure performed. Initial insured employees and dependents will remain at the same coinsurance level step during [2010] if they fail to visit the dentist and have one dental procedure performed.
2. For every January 1, thereafter, should any person fail to visit the dentist in any calendar year, or should he or she fail to have at least one dental procedure performed within the given year, the person will drop back one coinsurance level step, but never below the original Step 1 coinsurance level.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

MAXIMUM AMOUNT

The Maximum Amount can range between \$250 to \$10,000 or more in increments of \$50 dependent upon plan selection.

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as following:

When a Non-Participating Provider is used:
Maximum Amount - Each Benefit Period
\$[1,000]

When a Participating Provider is used:
Maximum Amount - Each Benefit Period
\$[1,250]

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [\$500] [per Lifetime, in any Benefit Period].

ELIMINATION (WAITING) PERIODS

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, the entire paragraph will be removed.

ORTHODONTIC EXPENSE BENEFITS

The Orthodontic Maximum Amount can range between \$250 to \$10,000 or more in increments of \$50 dependent upon plan selection.

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "each Benefit Period" or both.

If the Deductible Amount, Coinsurance, or Maximum Amount for Orthodontic expense benefits is different when utilizing a Participating Provider versus a Non-Participating Provider these amounts will be listed similar to the following:

	Participating Provider	Non-Participating Provider
Deductible Amount - Once per lifetime	\$100	\$150
Coinsurance Percentage	60%	50%
Maximum Benefit During Lifetime	\$1,500	\$1,000

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

If the policyholder has selected a plan with Takeover for Orthodontic Expense Benefits, the following will be listed:

The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [January 1, 2009], and
- b. on [January 1, 2009] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus
- b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Similar to the Dental Maximum Amount, if an internal maximum on Orthodontic Expense Benefits exists the following will be included:

Orthodontic Expense Benefits may not exceed \$[1,000] [in any Benefit Period, per Lifetime].

If the Policyholder has selected a plan in which the deductible for Dental and Orthodontic Expense Benefits are combined together so that the member only has to satisfy one deductible, the following will be included:

¹ The deductible is combined for both the Dental Expense and the Orthodontic Expense Benefits.

EYE CARE EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

The Deductible Amount for Eye Care Expense Benefits can range from \$0 to \$25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a \$25 Deductible on Lenses and Frames - Each Benefit Period. The deductible may also vary whether a Participating Provider or Non-Participating Providers is used.

The Maximum Amount for Eye Care Expense Benefits can range from \$50 to \$300 in \$50 increments or may be removed entirely if not included in the selected plan design.

Some services such as eye care exams, frames, or lenses may not apply to the Eye Care Maximum. If the policyholder has selected this plan than the following will be included:

[Eye Care Exams] are not subject to the Eye Care Maximum Amount.

Increasing Eye Care Maximum

If this plan is selected, the Member's eye care maximum will increase each benefit period up to the greatest amount in either the 3rd or 4th benefit period.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

[Maximum Amount - 1st Benefit Period	[\$0-350]
2nd Benefit Period	[\$0-350]
3rd Benefit Period	[\$50-400]
4th + Benefit Period	[\$50-400]]

LASER VISION CORRECTION EXPENSE BENEFITS

The Deductible Amount for Laser Vision Correction Expense Benefits can range from \$0 to \$250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

HEARING CARE EXPENSE BENEFITS

Deductible Amounts for Hearing Expense Benefits can range between \$0 to \$250 in increments of \$5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a \$50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

- i. during the last three months of any Benefit Period; and
- ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from \$400 - \$1,500 dollars in \$50 increments.

COMBINED EXPENSE BENEFITS

The Deductible Amount for Combined Expense Benefits, if selected by the policyholder, can range from \$10 to \$250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

In addition, an aggregate deductible amount may be included per lifetime. This would be a deductible amount limit that an Insured would satisfy once per lifetime then no other deductible would be required. If selected by the policyholder, the following would be included:

*Combined Dental and Eye Care Deductible Amount	\$200
Once per Lifetime	

The combined [Annual, Lifetime] deductible is subject to the Aggregate Lifetime deductible amount listed here.

The Combined Maximum Amount, if selected by the policyholder, can range from \$250 to \$10,000 or more in increments of \$50 based on plan selection.

The Combined Exam Frequencies, if selected by the policyholder, can range from 1 to 4 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

<i>SERFF Tracking Number:</i>	<i>AMFA-127622669</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Standard Insurance Company</i>	<i>State Tracking Number:</i>	<i>49870</i>
<i>Company Tracking Number:</i>	<i>SIC - 9270 VSP REV. 09-11</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>SIC - 9270 VSP Rev. 09-11</i>		
<i>Project Name/Number:</i>	<i>9270 VSP Rev. 09-11 /9270 VSP Rev. 09-11</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/26/2011	Form	EYE CARE EXPENSE BENEFITS	09/26/2011	9270 VSP Rev 09-11.pdf (Superseded)
09/26/2011	Supporting Document	Redline Versions	09/26/2011	9040 Rev. 09-11-rl.pdf 9270 VSP Rev 09-11-rl clean.pdf (Superseded)

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

[VSP is committed to your satisfaction. If your new plan has a benefit that is similar to the benefit provided under your preceding plan and the lenses and frames you received were the same as those covered under your preceding plan, VSP will, upon your request, assist you with any transitional issues relating to these lenses and frames you may experience during the first year of your VSP coverage. Contact VSP Member Services at 800.877.7195 for more details.]

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services below.

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 PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. [Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195].

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 may be 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 [arranged differently through an Affiliate or Open Access provider, or] otherwise required by state regulation.

EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED

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

PROOF OF LOSS

Written proof of loss must be given to us within [180] days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

[LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.]

[EXCLUSIONS

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits,
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,
- Two pairs of glasses in lieu of Bifocals,
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,
- Orthoptics or vision training and any associated supplemental testing,
- Medical or surgical treatment of the eyes,
- Contact lens modification, polishing or cleaning,
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology,
- Local, state and/or federal taxes, except where law requires us to pay,
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.]

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		Participating Provider	Non-Participating Provider[*]
[Vision Examination(s)]			
[Eye Exam]	[Once] every [XX] [months]	Covered in Full	Up to \$ [52.00]
[Retinal Screening]	[Once] every [XX] [months]	Covered in Full	[See Eye Exam benefit above]
[Contact Lens Fitting & Evaluation]	[Once] every [XX] [months]	[Covered in Full] [See Elective Contact Lenses benefit below]	[See Elective Contact Lenses benefit below]
[Prescription Safety Eyewear]	[Once] every [XX] [months]	Covered in Full	Up to \$ [8.00]
[Complete Pair of Spectacles]			
[Lenses (per pair, only one pair of lens type below allowed per covered period) [includes Safety Eyewear]			
[Single Vision]	[Once] every [XX] [months]	Covered in Full	Up to \$ [55.00]
[Lined Bifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [75.00]
[Lined Trifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [95.00]
[Lenticular]	[Once] every [XX] [months]	Covered in Full	Up to \$ [125.00]
[Progressive]	[Once] every [XX] [months]	Up to an Agreed Amount [#]	Up to \$ [20.00 – 300.00]
[Frames]			
[Single Frame][%]	[Once] every [XX] [months]	Up to \$ [40.00 – 300.00]	Up to \$ [30.00 – 300.00]
[Safety Eyewear Frame^]	[Once] every [XX] [months]	Up to \$ [80.00]	Up to \$ [40.00]
[Contact Lenses (in lieu of Complete Pair of Spectacles) [Includes allowance for Contact Len Fitting & Evaluation]			
[Elective]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Medically Necessary]	[Once] every [XX] [months]	Covered in Full	Up to \$ [210.00]

[Low Vision (for sever visual problems not correctable with regular lenses, as determined by the treating provider)
Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.]

[*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider]

[#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 base lens and the Progressive Lenses charge.]

[%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.]

[^Lenses prescribed for safety eyewear must be no less than 3 millimeters at the thinnest point, impact tested with a one-inch steel ball dropped from a height of 50 inches, and engraved by the manufacturer that it is a safety lens.]

[^Frames prescribed for safety eyewear must have a Z-87 stamp on the front and temples, be fabricated of a slow burning material, have a manufacturer's logo imprint, and be constructed so that, if impacted from the front, the lens will not come out through the back of the frame]

[SUPPLEMENTAL EYE CARE BENEFIT

This rider lists additional eye care care benefits to which Insureds are entitled, subject to any applicable Deductible Amount and other conditions, limitations and/or exclusions stated herein. Benefits under the Supplemental Eye Care Benefit Rider are available to Insureds only after applicable benefits under their group medical plan have been exhausted, or when the Insured is not covered under a group medical plan. This rider forms a part of the Policy and Evidence of Coverage to which it is attached.

This rider is designed to cover procedures related to the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Eye care professionals provide treatment and management of urgent and follow-up services, including management of conditions which require monitoring to prevent future vision loss.

The eye care professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the eye care professional to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

There is no coverage provided under this rider for the following:

1. Costs associated with securing frames, lenses or any other materials.
2. Orthoptics or vision training and any associated supplemental testing.
3. Laser or any other form of refractive surgery or procedure.
4. Pathological treatment.
5. Any eye examination required by an employer as a condition of employment.
6. Medication.
7. Pre- and post-operative services.
8. Services and/or materials not indicated on this rider as Covered Services.

COVERED SERVICES

SERVICE CATEGORY	CONTRACTING PROVIDER BENEFIT	NON-CONTRACTING PROVIDER BENEFIT (Plan Pays)
CATEGORY A Services	Covered in full after \$ [5.00-50.00] Deductible per visit	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable
CATEGORY B Services	Covered in full	[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable

COVERED SERVICES by CATEGORY

PROCEDURE CODE	DESCRIPTION
CATEGORY A Services	
92002, 92004, 92012, 92014, 92070*	Ophthalmological services
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	Office Visits
99050, 99051	Afterhours services; additional services
99241, 99242, 99243, 99244, 99245	Office consultations
CATEGORY B Services	
92020*, 92025*	Gonioscopy
92081, 92082, 92083	Visual field exams
92100*	Serial tonometry
92120	Tonography with interpretation and report
92130	Tonography with water provocation
92140	Provocative tests for glaucoma
92225, 92226*	Extended Ophthalmoscopy

COVERED SERVICES by CATEGORY (cont.)

Procedure Code	Description
92250	Fundus Photography
92260	Ophthalmodynamometry
92270	Electro-oculography with interpretation and report
92275	Electroretinography with interpretation and report
92283	Color vision exam, extended
92284	Dark adaptation exam with interpretation and report
92285*	External ocular photography
92286*	Special anterior segment photography
92287*	Special anterior segment photography with fluorescein angiography
95930	Visual evoked potential (VEP) testing central nervous system
65205, 65210, 65220, 65222	Removal, foreign body, external eye
65430	Scraping of cornea
65435	Removal of corneal epithelium
67820	Correction of trichiasis
67938	Removal of embedded foreign body, eyelid
68761*	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum
68810, 68815*	Probing of nasolacrimal duct
76514*	Corneal pachymetry, unilateral or bilateral

*Service and/or diagnosis limitations apply or procedure requires special handling. VSP Network Doctors must contact VSP for details before rendering services.]

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

Deleted: may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to

[VSP is committed to your satisfaction. If your new plan has a benefit that is similar to the benefit provided under your preceding plan and the lenses and frames you received were the same as those covered under your preceding plan, VSP will, upon your request, assist you with any transitional issues relating to these lenses and frames you may experience during the first year of your VSP coverage. Contact VSP Member Services at 800.877.7195 for more details.]

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AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of the provider's charge, or the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services below.

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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 PROVIDERS

A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS

A Non-Participating Provider is any other provider. [Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP's Customer Care Division for details at (800) 877-7195.]

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 may be limited to those for a Non-Participating Provider.

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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 [arranged differently through an Affiliate or Open Access provider, or] otherwise required by state regulation.

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EXTENSION OF BENEFITS

If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy's termination. You will have six months following the date of service to submit your claim.

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EXPENSES INCURRED

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

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PROOF OF LOSS

Written proof of loss must be given to us within [180] days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS

This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS

This plan does not cover:

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below.
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses.
- Two pairs of glasses in lieu of Bifocals.
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

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SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section. You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE	
		Participating Provider	Non-Participating Provider[*]
[Vision Examination(s)]			
[Eye Exam]	[Once] every [XX] [months]	Covered in Full	Up to \$ [52.00]
[Retinal Screening]	[Once] every [XX] [months]	Covered in Full	[See Eye Exam benefit above]
[Contact Lens Fitting & Evaluation]	[Once] every [XX] [months]	[Covered in Full]	[See Elective Contact Lenses benefit below]
[Prescription Safety Eyewear]	[Once] every [XX] [months]	Covered in Full	Up to \$ [8.00]
[Complete Pair of Spectacles]			
[Lenses (per pair, only one pair of lens type below allowed per covered period) [includes Safety Eyewear]			
[Single Vision]	[Once] every [XX] [months]	Covered in Full	Up to \$ [55.00]
[Lined Bifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [75.00]
[Lined Trifocal]	[Once] every [XX] [months]	Covered in Full	Up to \$ [95.00]
[Lenticular]	[Once] every [XX] [months]	Covered in Full	Up to \$ [125.00]
[Progressive]	[Once] every [XX] [months]	Up to an Agreed Amount [#]	Up to \$ [20.00 - 300.00]
[Frames]			
[Single Frame][%]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Safety Eyewear Frame^]	[Once] every [XX] [months]	Up to \$ [80.00]	Up to \$ [40.00]
[Contact Lenses (in lieu of Complete Pair of Spectacles) [Includes allowance for Contact Len Fitting & Evaluation]			
[Elective]	[Once] every [XX] [months]	Up to \$ [40.00 - 300.00]	Up to \$ [30.00 - 300.00]
[Medically Necessary]	[Once] every [XX] [months]	Covered in Full	Up to \$ [210.00]
[Low Vision (for sever visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.]			
[*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider]			
[#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 base lens and the Progressive Lenses charge.]			
[%Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Customer LASIK patients as determined by the VSP Participating Provider. Frame allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility.]			

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[^Lenses prescribed for safety eyewear must be no less than 3 millimeters at the thinnest point, impact tested with a one-inch steel ball dropped from a height of 50 inches, and engraved by the manufacturer that it is a safety lens.]

[^Frames prescribed for safety eyewear must have a Z-87 stamp on the front and temples, be fabricated of a slow burning material, have a manufacturer's logo imprint, and be constructed so that, if impacted from the front, the lens will not come out through the back of the frame]

[SUPPLEMENTAL EYE CARE BENEFIT

This rider lists additional eye care care benefits to which Insureds are entitled, subject to any applicable Deductible Amount and other conditions, limitations and/or exclusions stated herein. Benefits under the Supplemental Eye Care Benefit Rider are available to Insureds only after applicable benefits under their group medical plan have been exhausted, or when the Insured is not covered under a group medical plan. This rider forms a part of the Policy and Evidence of Coverage to which it is attached.

This rider is designed to cover procedures related to the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Eye care professionals provide treatment and management of urgent and follow-up services, including management of conditions which require monitoring to prevent future vision loss.

The eye care professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the eye care professional to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

There is no coverage provided under this rider for the following:

1. Costs associated with securing frames, lenses or any other materials.
2. Orthoptics or vision training and any associated supplemental testing.
3. Laser or any other form of refractive surgery or procedure.
4. Pathological treatment.
5. Any eye examination required by an employer as a condition of employment.
6. Medication.
7. Pre- and post-operative services.
8. Services and/or materials not indicated on this rider as Covered Services.

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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]¶
<#>Prescription Safety Lenses must meet
the following conditions:¶
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must meet the following conditions:¶
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COVERED SERVICES

<u>SERVICE CATEGORY</u>	<u>CONTRACTING PROVIDER BENEFIT</u>	<u>NON-CONTRACTING PROVIDER BENEFIT (Plan Pays)</u>
<u>CATEGORY A Services</u>	<u>Covered in full after \$ [5.00-50.00] Deductible per visit</u>	<u>[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable</u>
<u>CATEGORY B Services</u>	<u>Covered in full</u>	<u>[80%] of the lesser of provider's Usual and Customary Charge or the Medicare Allowable</u>

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COVERED SERVICES by CATEGORY

<u>PROCEDURE CODE</u>	<u>DESCRIPTION</u>
<u>CATEGORY A Services</u>	
<u>92002, 92004, 92012, 92014, 92070*</u>	<u>Ophthalmological services</u>
<u>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</u>	<u>Office Visits</u>
<u>99050, 99051</u>	<u>Afterhours services; additional services</u>
<u>99241, 99242, 99243, 99244, 99245</u>	<u>Office consultations</u>
<u>CATEGORY B Services</u>	
<u>92020*, 92025*</u>	<u>Gonioscopy</u>
<u>92081, 92082, 92083</u>	<u>Visual field exams</u>
<u>92100*</u>	<u>Serial tonometry</u>
<u>92120</u>	<u>Tonography with interpretation and report</u>
<u>92130</u>	<u>Tonography with water provocation</u>
<u>92140</u>	<u>Provocative tests for glaucoma</u>
<u>92225, 92226*</u>	<u>Extended Ophthalmoscopy</u>

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COVERED SERVICES by CATEGORY (cont.)

Procedure Code	Description
<u>92250</u>	<u>Fundus Photography</u>
<u>92260</u>	<u>Ophthalmodynamometry</u>
<u>92270</u>	<u>Electro-oculography with interpretation and report</u>
<u>92275</u>	<u>Electroretinography with interpretation and report</u>
<u>92283</u>	<u>Color vision exam, extended</u>
<u>92284</u>	<u>Dark adaptation exam with interpretation and report</u>
<u>92285*</u>	<u>External ocular photography</u>
<u>92286*</u>	<u>Special anterior segment photography</u>
<u>92287*</u>	<u>Special anterior segment photography with fluorescein angiography</u>
<u>95930</u>	<u>Visual evoked potential (VEP) testing central nervous system</u>
<u>65205, 65210, 65220, 65222</u>	<u>Removal, foreign body, external eye</u>
<u>65430</u>	<u>Scraping of cornea</u>
<u>65435</u>	<u>Removal of corneal epithelium</u>
<u>67820</u>	<u>Correction of trichiasis</u>
<u>67938</u>	<u>Removal of embedded foreign body, eyelid</u>
<u>68761*</u>	<u>Closure of lacrimal punctum</u>
<u>68801</u>	<u>Dilation of lacrimal punctum</u>
<u>68810, 68815*</u>	<u>Probing of nasolacrimal duct</u>
<u>76514*</u>	<u>Corneal pachymetry, unilateral or bilateral</u>

*Service and/or diagnosis limitations apply or procedure requires special handling. VSP Network Doctors must contact VSP for details before rendering services.]

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 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. ¶

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

¶
 ** 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.

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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.		
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7) This plan does not cover Medically Necessary Contact Lenses more than once in any 24-month period.		
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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		
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refitting of Contact Lenses after the initial 90-day fitting period,		
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10) This plan does not cover Plano		
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Lenses to change eye color.		
11) This plan does not cover artistically painted Contact Lenses.		
12) This plan does not cover contact lens		
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insurance policies or service contracts,		
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13) This plan does not cover additional		
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14) This plan does not cover contact lens modification, polishing or cleaning.		
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15) This plan does not cover Orthoptics or vision training and any associated testing.		
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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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. No benefits are payable for a service not listed.

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SERVICE

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(All lenses are per pair)
Single Vision Lenses

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Up to \$ [55.00

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Lined Bifocal

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Lined Trifocal Lenses

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Lenticular Lenses

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Progressive Lenses	Up to an Agreed Amount**	Up to \$ [20.00-300.00]
Frame	\$ Up to [60.00-300.00]	Up to \$ [30.00-300.00]

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