

DELTA DENTAL OF TENNESSEE

DeltaVision® INDIVIDUAL VISION CARE POLICY

TABLE OF CONTENTS

REQUIRED PROVISIONS	2
DEFINITIONS OF WORDS AND PHRASES USED IN THIS POLICY	4
PLAN BENEFITS	5
WHAT YOU NEED TO KNOW ABOUT USING YOUR PLAN BENEFITS	6
HOW DELTA DENTAL HANDLES PAYMENT OF CLAIMS	7
EXCLUSIONS AND LIMITATIONS OF BENEFITS	8
NOT COVERED	8

This Policy is a legal contract between the policy owner and the company.

READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your policy. This cover sheet is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and Obligations of both you and your insurance company. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.**

DeltaVision® INDIVIDUAL VISIONCARE POLICY

Provided By

**Delta Dental of Tennessee
240 Venture Circle, Nashville, TN 37228**

POLICY NUMBER: V7801

POLICYHOLDER'S NAME:

COVERED DEPENDENTS: Betty Ynzunza - Policyholder;

POLICY EFFECTIVE DATE: 05/01/2020

PREMIUM: \$8.14 \$ [] per Plan Year

STATE OF DELIVERY: Tennessee

ADMINISTRATOR:

Administered by: VSP (Vision Service Plan)

Customer Care: 1-800-877-7195

Address for Claims: PO Box 385018, Birmingham, AL 35238-5018

RIGHT TO RETURN THE POLICY IN 10 DAYS

You, the Policy holder under this Policy, shall be permitted to return this Policy within ten (10) days. You may have the premium paid refunded if You are not satisfied with it for any reason. If You return this Policy to Delta Dental of Tennessee (Delta Dental) or to the broker or agent from whom You purchased it, it shall be void from the beginning. This means that You will be responsible for payment in full of any services received or materials purchased from the Policy Effective Date to the date the Policy is voided. If this Policy is voided, Delta Dental will not be liable for payment of any Plan Benefits utilized by any Covered Person under this Policy.

The benefits available under this Policy are provided by Delta Dental of Tennessee (Delta Dental) through a DeltaVision Policy. The Policy is administered by VSP (Vision Service Plan). For any questions or problems concerning any provisions of this Plan, please contact VSP at 1-800-877-7195. Or write to PO Box 385018, Birmingham, AL 35238-5018.

REQUIRED PROVISIONS ENTIRE CONTRACT: CHANGES

This Policy, including the Schedule of Benefits, endorsements, and any other attached papers constitutes the entire contract of insurance. A change in this Policy is not valid approved by an executive officer of Delta Dental and the approval is endorsed on or attached to this Policy. A broker or other agent does not have authority to change this Policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the issue date of this Policy no misstatements made by shall be used to void this Policy or to deny a claim for a loss incurred.

GRACE PERIOD

The premium due date is the first of the month. There is a grace period of thirty-one (31) days. If premium is not received by the end of the grace period, this Policy will be cancelled.

LEGAL ACTION

You must wait 60 days after submitting a claim to Delta Dental before taking legal action. Your claim for benefits must be sent following the guidelines in this policy. You may not take legal action if it has been 3 years or more from the date of service

CLAIM FORMS

If you need a claim form, Delta Dental will provide one to you. Delta Dental will provide a claim form within 15 days from the time you tell us you had a claim. If Delta Dental does not provide you a claim form, you will be deemed to have met the time limit for filing your proof of loss.

RENEWABILITY

This Policy is conditionally renewable. The Policyholder must have paid premium in a timely manner. The Policyholder must not have committed fraud. Delta Dental must continue to offer this plan in the state of Tennessee.

DEFINITIONS OF WORDS AND PHRASES USED IN THIS POLICY

Words and phrases that are not defined elsewhere in the Policy have the following meanings:

Administrator	The entity designated by Delta Dental to administer the Plan Benefits described in this policy. Currently the Administrator is Vision Service Plan Insurance Company ("VSP®").
Benefit Authorization	Authorization from Delta Dental or its Administrator identifying the individual named as a Covered Person of Delta Dental, and identifying those Plan Benefits to which Covered Person is entitled at the time the authorization is issued.
Copay	An amount required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
Covered Dependent	A Policyholder's eligible dependent who is covered under this Policy.
Covered Person	A person insured under this Policy, including the Policyholder and any Covered Dependent. Also known as a Member.
Delta Dental of Tennessee ("Delta Dental")	Delta Dental of Tennessee, a Tennessee not-for-profit dental services corporation or its Administrator.
DeltaVision™	The vision care products and plans underwritten by Delta Dental
Open Access Provider	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with Delta Dental or its Administrator to provide vision care services and/or vision care materials to Covered Persons.
Member	A person insured under this Policy, including the Policyholder and any Covered Dependent.
Plan Year	A twelve-(12) month period beginning on the Plan Effective Date of this Policy and on each subsequent anniversary thereof.
Policy	This document and all of its attachments, if any.
Policy holder	The person who signed the application for this Policy and who is responsible for payment of premiums for this Policy.
You, Your	The person insured under this Policy. The Policyholder.
Preferred Provider	An optometrist or ophthalmologist, licensed and otherwise qualified to practice vision care and/or provide vision care materials, who has contracted with Delta Dental or its Administrator to provide Plan Benefits on behalf of Covered Persons.
We, Us, Our, Delta Dental	This refers to Delta Dental of Tennessee.

PLAN BENEFITS

During each Plan Year the following vision care services and/or materials are available to Members under this Policy:

Exam

Each Plan Year, each Member is allowed to one complete vision exam. It will include an exam of visual functions and prescription of corrective eyewear where needed. At the time of the exam, You will pay the Preferred Provider a Copay of \$10.00. You will not pay for any other charges for the exam.

Lenses*

Each Plan Year, each Member is entitled one pair of prescription lenses. For each pair of lenses a Member receives You will be responsible for paying the Preferred Provider the Copay.[†] You will be charged for any materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limits."

For Lenses, a Copay of \$20.00.

Frames*

Each Plan Year, each Member is entitled to an allowance of \$150.00 toward the purchase of one set of frames. For each set of frames Members receive, You will be responsible for paying the Preferred Provider:

- 1) Copay of \$20.00[†].
- 2) Costs for the purchase of the frames which exceed Your plan allowance
- 3) Charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limits."

Your Plan Benefits for frames and lenses shall also include necessary professional services such as:

- prescribing and ordering proper lenses
- assisting in frame selection
- verifying accuracy of finished lenses
- proper fitting and adjustments of frames
- subsequent adjustments to frames to maintain comfort and efficiency
- progress or follow-up work as necessary

[†] If both frames and lenses are purchased separately during a single Plan Year, the \$20.00 Copay will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Year, only one \$20.00 Copay will be required for the combined purchase.

Contact Lenses*

Each Plan Year each Member is entitled to an allowance of \$150.00 toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. An additional discount of fifteen percent (15%) will apply to the Preferred Provider professional fee. For each pair of extended wear contact lenses or for each supply of disposable contact lenses Members receive, You will be responsible for paying the Preferred Provider:

- 1) Any amounts which exceed Your Plan allowance
- 2) Any charges for services and/or materials not covered under this Policy.

For a list of non-covered services and materials, please refer to the section entitled "Plan Limits."

***Important:** Under this Policy, each Plan Year, Members may purchase either 1) one pair of prescription eyeglasses (frame and lenses), or 2), one pair of extended wear contact lenses or a supply of disposable contact lenses.

OTHER PLAN BENEFITS

Members are also entitled to receive the additional vision care services as stated below.

Additional Discount

In addition to the specific Plan Benefits stated above, Members are entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (frames, lenses and Lens Options) from Preferred Providers. Additional pairs are those purchased beyond the Plan Year benefit frequency allowed under this Policy.

Members are may receive a discount of fifteen percent (15%) off of any Preferred Provider's professional fees for evaluation and fitting of contact lenses.

You will be responsible for paying the Preferred Provider the balance of any charges for materials and services after the applicable discount(s) are applied. To receive the discount(s), all services and/or materials must be purchased within twelve (12) months of an examination covered under this Policy. Purchases must be from a Preferred Provider.

Important: Additional Discounts do not apply to vision care services and/or materials obtained from an Open Access Provider.

WHAT YOU NEED TO KNOW ABOUT USING YOUR PLAN BENEFITS:

How to obtain services and materials under this Policy

When Members want to receive Plan Benefits, contact a Preferred Provider and make an appointment. Identify Yourself as a DeltaVision® member. The Preferred Provider will contact Delta Dental to verify Your eligibility. They will obtain a Benefit Authorization. You should refer to the list of Preferred Providers on our website for the names of the Preferred Providers in Your area. You may also find the locations of Preferred Providers by calling Customer Care toll-free at the number listed on page 2 of this Policy. Members are not limited to any geographic area when they wish to use Plan Benefits. They may select a Preferred Provider anywhere throughout the United States.

Why a Benefit Authorization is required

A Benefit Authorization is Delta Dental's way of confirming that Members are eligible to receive Plan Benefits. If Members receive Plan Benefits before the Authorization expires, Delta Dental will pay for those Plan Benefits even if this Policy is terminated. If Members receive Plan Benefits without a Benefit Authorization, You will be responsible for paying the full amount of the services and/or materials to the doctor. You may then file a claim with Delta Dental and Delta Dental will reimburse you for the Plan Benefits you received. If You cancel and return this Policy within ten (10) days of purchase, You will be responsible for payment of all expenses incurred by Members for services or materials, even if Delta Dental has issued a Benefit Authorization.

Plan Benefits received from an Open Access Provider

Members may receive Plan Benefits from any duly licensed optometrist or ophthalmologist. If Members receive Plan Benefits from an Open Access Provider, You will be responsible for paying the provider's full fee. You will request reimbursement from Delta Dental. The amount reimbursed to You by Delta Dental may be less than what is owed. Preferred Providers have agreed to accept discounted fees for their services. Preferred Providers agreed to not bill You for Plan Benefits covered under this Policy. Open Access Providers do not have such an agreement with Delta Dental. They can charge You their full fees. Also, Delta Dental cannot require Open Access Providers to follow its quality standards. Plan Benefits received from an Open Access Provider will exhaust Members' Plan Benefits under this Policy. Members may not receive similar Plan Benefits from both a Preferred Provider and an Open Access Provider. For example, if We pay for an exam from a Preferred Provider, no Plan Benefits will be available for an exam from an Open Access Provider.

Emergency services

Plan Benefits provided by Delta Dental under this Policy are for routine vision care services and materials only. This

Policy does not cover treatment for medical conditions, whether due to an emergency or to any other cause. If You or any of Your Covered Dependents require medical treatment for any reason, You should contact a medical provider.

Your rights under this Policy if You have problems or questions

For any questions You may have regarding Your coverage under this Policy, please contact Customer Care Division at the number listed on page 2 of this Policy during normal business hours. Many of Your questions may also be answered by visiting the web site listed on page 2 of this Policy.

If You should ever have a complaint about the quality of the care You receive from a Preferred Provider, wish to request reconsideration from Delta Dental of a claim denied for payment, or for any other matter, Your first step should be to contact Customer Care Division. If they are not able to resolve Your complaint, they will assist You in the procedures for pursuing a formal review of Your concerns by Delta Dental. For additional information on this matter, please refer to the section of this Policy entitled "How Delta Dental handles payment of claims."

HOW DELTA DENTAL HANDLES PAYMENT OF CLAIMS

Plan Benefits under this Policy are underwritten by Delta Dental of Tennessee, and are subject to preferred provider arrangements.

A preferred provider, referred to in this Policy as a "Preferred Provider," is an optometrist or ophthalmologist that has signed a contract with Delta Dental to provide Plan Benefits to Covered Persons under Delta Dental policies. Each Preferred Provider has agreed to accept discounted fees as payment from Delta Dental in exchange for being listed in its directory of its contracting doctors. A doctor who is not a Preferred Provider has no contractual arrangement with Delta Dental and can charge whatever fee he or she desires. You can obtain more information regarding preferred providers, including a list of doctors in Your area, by visiting the web site listed on page 2 of this policy. You may also call Customer Care Division.

Services from Preferred Providers

When You or Your Covered Dependents receive services or materials from a Preferred Provider, the doctor will submit any required claims directly to Delta Dental. Delta Dental will then pay the doctor for the Plan Benefits You or Your Covered Dependents received. You will never be required to file a claim with Delta Dental. If Delta Dental fails to pay the Preferred Provider, neither You nor any of Your Covered Dependents will be held liable for any sums owed by Delta Dental other than those not covered by Delta Dental under this Policy.

Services from Open Access Providers

When You or Your Covered Dependents receive services or materials from an Open Access Provider, You may be required by the provider to pay the charges in full. You would then need to submit a claim or other "proof of loss" to Delta Dental for reimbursement. You do not need a special claim form in order to request reimbursement from Delta Dental. At a minimum, with any request for reimbursement, You should include:

- Your name
- Your Member Identification Number
- the name of the patient
- the patient's date of birth
- the date the services were rendered and/or materials provided
- the amounts You paid for each service or material
- the doctor's name
- copies of any invoices or receipts You received from the doctor for the services or materials.

Mail Your request for reimbursement to VSP® at the following address:

VSP®
PO Box 385018
Birmingham, AL 35238-5018

You will be reimbursed for the services or materials based on the following Open Access Provider Schedule of Allowances:

Open Access Provider Schedule of Allowances	
Service or Material	Allowance
Examination	\$ 45.00
Single Vision Lens (pair)	\$ 30.00
Bifocal Lens (pair)	\$ 50.00
Trifocal Lens (pair)	\$ 65.00
Lenticular Lens (pair)	\$ 100.00
Frame	\$ 70.00
Contact Lens (pair)	\$ 105.00

(This schedule is updated annually on January 1st of each year. When updated, allowances may change from those stated above.)

Proof of loss (a claim)

You must send your claim for reimbursement to Delta Dental within 365 days of the date of service. Send Your claim to the address stated above. If You do not send Your claim within 365 days, Delta Dental may not reimburse your claim. If the event of legal incapacity, You will have more time to file your claim.

Time of payment of claims

Any amounts owed to You will be paid within thirty (30) days of receipt of the proof of loss.

Payment of Claims

Any amounts owed to you at the time of Your death will be paid to the Your estate. All other claims will be paid to You.

Other insurance coverage

Delta Dental will not coordinate Plan Benefits payable under this Policy with any other private or government insurance plan. This includes other plans underwritten by Delta Dental.

Denial of payment for claims

If Delta Dental denies a claim, You have the right to request a review of the denial. Also, if Delta Dental denies Your request for review of the claim, You have the right to appeal this decision. If you get a notice of denial, You have 60 days to request an appeal. Delta Dental will give You a written internal appeal decision within thirty (30) days of Your request. All written notices of denial will include the steps of the internal appeals process.

You may request a reconsideration of a denial by contacting Customer Care at 1-800-877-7195. You may also call Customer Care at 1-800-877-7195 to obtain more information on the appeals process.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. You may obtain details regarding frame brand availability from their Preferred Provider or by calling Customer Care at 1-800-877-7195.

NOT COVERED

The following services and/or materials are not covered under this Policy.

1. Services and/or materials not included as Plan Benefits in this Policy.
2. Orthoptics or vision training and any associated supplemental testing.
3. Corneal Refractive Therapy (CRT)
4. Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
5. Refitting of contact lenses after the initial (90-day) fitting period.
6. Plano lenses (lenses with refractive correction equal to or less than $\pm .50$ diopter).
7. Two pair of glasses in lieu of bifocals.
8. Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available.
9. Medical or surgical treatment of the eyes.
10. Plano contact lenses to change eye color cosmetically.
11. Artistically-painted contact lenses.
12. Contact lens insurance policies or service contracts.
13. Additional office visits associated with contact lens pathology.
14. Contact lens modification, polishing or cleaning.
15. Costs for services and/or materials exceeding Plan Benefit allowances.
16. Services or materials of a cosmetic nature.
17. Local, state and/or federal taxes, except where Delta Dental is required by law to pay.