DeltaVision™ in partnership with VSP™

Delta Dental of Tennessee
240 Venture Circle Nashville, TN 37228
Phone (800) 223-3104 Fax (615) 244-8108
VSP Customer Care (800) 877-7195
www.DeltaDentalTN.com
www.VSP.com

Certificate of Coverage

Table of Contents

Introduction

This Certificate of Coverage (COC) is a guide to your dental plan. It is not the contract between Delta Dental of Tennessee (DDTN) and your group or any member of the plan. Should there be any conflict between the COC and the contract, the contract will prevail.

This vision plan is underwritten by Delta Dental of Tennessee. Some functions of this plan are administered by VSP.

I. Eligibility and Enrollment of Subscribers and Dependents

As an enrollee in this plan, you may also enroll your dependents.

Dependents are defined as a lawful husband or wife or other relationship as defined by the group or child(ren) from birth to the Dependent Age Limit listed on the Benefit Summary Page. "Child" includes a natural child, step-child, adopted child, foster child or child in the subscriber's legal custody. A child over the Dependent Age Limit may continue to be eligible. The child must not be able to support them self because of mental incapacity or physical handicap. Such disabling condition must have begun before reaching the Dependent Age Limit. Proof of these facts must be given to DDTN or group within 31 days if requested. Proof will not be required more than once a year.

Dependents in military service are not eligible.

Your dependents must enroll along with you or as soon as they become dependents. If dependents do not enroll at this time, they must wait until the next open enrollment period to enroll. Your dependents may not be enrolled without your enrollment, but you may drop dependent coverage and maintain your coverage.

If you or your dependents drop coverage but still meet all requirements of the plan, you may re-enroll during the first open enrollment period after having been out of the plan for 12 consecutive months except in the event of a qualified life status change.

You or your dependent's coverage terminates when you are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to the administrator of your group to see if an extension is available and for how long the benefits could be extended.

DDTN will not pay for any services received by a patient who is not eligible at the time of treatment. Coverage for you and your dependents is only effective after DDTN receives the premium for the period to be covered. If DDTN does not receive the premium when it is due, we may stop paying claims until payment is received. If premiums have not been received within 30 days after the due date, DDTN may cancel the contract with the group. DDTN does not bill individuals for premiums.

This contract may be cancelled upon renewal by DDTN with 30 days prior written notice or by the Group with 15 days prior written notice.

II. Choosing a Preferred Provider

A preferred provider, referred to in this Policy as a "Preferred Provider," is an optometrist or ophthalmologist that has signed a contract with VSP to provide Plan Benefits to You under Delta Dental policies. Each Preferred Provider has agreed to accept discounted fees as payment from VSP 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 or VSP 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 the Benefit Summary Page. You may also call VSP Customer Care.

DDTN is not responsible for any injuries or damages suffered due to the actions of any provider.

III. How to use this plan

DeltaVision in partnership with VSP provides Plan Benefits to You (you and/or your covered dependents) based on the level of coverage purchased by the group. Refer to the Benefit Summary, Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that you are a DeltaVision in partnership with VSP member. Should You fail to identify yourself as a VSP member, Plan Benefits shall be limited to those of an Open Access Provider.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and You are responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, You may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. If an Open Access Provider agrees to submit a claim to VSP on your behalf, VSP will reimburse the Provider directly if the claim includes a valid Assignment of Benefits. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for You. All claims must be submitted to VSP within 365 calendar days from the date services are rendered and/or materials provided. Claims received by VSP after 365 days will be denied unless prohibited by applicable state or federal law.

Urgent Vision Care

Services for conditions of a medical nature are covered by Delta Dental only under specific supplemental eye care Plans purchased by the group. If the group purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, You may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for You to obtain vision care for Urgent Conditions of a medical nature. If the group

has not purchased one of these plans, You are not covered by Delta Dental for medical services and should contact a physician under Your medical insurance plan for care.

IV. General Provisions

A. If you or your covered dependent receive an injury requiring vision care treatment because of the action or fault of another person VSP may pay benefits. If there is other coverage of which DDTN is unaware, VSP would assume your or your covered dependent's rights to recover from the other person. You and your covered dependent would be required to help DDTN in making such a recovery.

B. This plan does not replace any workers' compensation coverage.

C. If you or your covered dependent has two vision care coverages, VSP will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
   1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
   2. Where the patient is a dependent child, primary coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e. stepparent) will be primary.
   3. If there is a court decree stating that one parent has financial responsibility for a child's vision care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

D. VSP will pay or deny claims within thirty (30) days of receipt. If any payment for services was denied, VSP will give the reason why. If you disagree with the denial you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request for your first level review must be received by VSP within 180 days of your receipt of the denial. VSP will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to you within 30 days after VSP receives the request for review.

   If you do not agree with the first level review decision, you may request a second level review. The manner in which to seek a second level review will be included with the letter informing you of our first level review decision.

   The second level review decision will be made no later than 30 days from the date we receive your request. If you do not agree with the second level review decision, you may file civil action in court within one year of the final denial.

V. Benefits

The Schedule of Benefits in this COC reflects the services that are covered as well as certain limitations and exclusions for these covered benefits. These services will be covered when a vision care professional that is licensed to perform the service provides them. These services must be necessary and must be provided in accordance with generally accepted practice standards. Some allowable services are subject to copayments, allowances and frequency limitations as described on the Benefit Summary.

In addition to the limitations and exclusions shown in the Schedule of Benefits section, DDTN does not pay for the following:

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 your VSP Preferred Provider. You may also call VSP's Customer Care.

Not Covered

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.

- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Group.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where Delta Dental is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology

VI. Schedule of Benefits

Refer to your Summary of Benefits for specific copayment amounts, allowances and time limitations.

Plan Benefits – Preferred Providers

Copayment

There shall be a Copayment for the examination payable by You at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services and Materials

Eye Examination - Comprehensive examination of visual functions and prescription of corrective eyewear.

Lenses – Covered in full after the copayment. This includes spectacle lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular). Polycarbonate lenses are covered in full for dependent children up to age 26. Standard Progressive Lenses are covered in full after copayment (if applicable).

Frames - Covered up to the Plan allowance less copayment (if applicable). The VSP Preferred Provider will prescribe and order Your lenses, verify the accuracy of finished lenses, and assist You with frame selection and adjustment.

Contact Lenses

Elective - Elective Contact Lenses (materials only) are covered up to the plan allowance. The Elective Contact Lens fitting and evaluation services are covered in full after copayment. .

Necessary - Necessary Contact Lenses are covered up to the plan allowance less copayment (if applicable). Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

Plan Benefits – Open Access Providers

Copayment

You will pay a Copayment for the examination at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Covered Services and Materials

Eye Examination - Comprehensive examination of visual functions and prescription of corrective eyewear.

Lenses -

Single Vision: Up to the plan allowance

Bifocal: Up to the plan allowance
Trifocal: Up to the plan allowance
Lenticular: Up to the plan allowance

Frames - Covered up to the plan allowance

Contact Lenses -

Elective - Elective Contact Lenses are covered up to the plan allowance. The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary - Necessary Contact Lenses are covered up to the plan allowance. Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits.

VII. Additional Benefit Rider – Supplemental Primary Eyecare Plan

General

This Rider lists additional vision care benefits to which DeltaVision members are entitled. There are copayments, limitations and exclusions that will apply. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Certificate of Coverage.

Plan Benefits under the Supplemental Primary EyeCare Plan are available to You only after all other benefits under their group medical plan have been exhausted. Coverage is also available if You are not covered under a group medical plan.

If You have the following symptoms and/or conditions (see below) You will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

Symptoms: Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the Plan may include, but are not limited to:

- ocular discomfort or pain
- onset of eye muscle dysfunction
- transient loss of vision
- ocular foreign body sensation
- flashes or floaters
- pain in or around the eyes
- ocular trauma
- swollen lids
- diplopia
- red eyes

Conditions: Examples of conditions which may require management under the Plan may include, but are not limited to:

- ocular hypertension
- macular degeneration
- retinal nevus
- corneal dystrophy
- glaucoma
- corneal abrasion
- cataract
- blepharitis
- pink eye
- sty

Procedures for Obtaining Supplemental Primary Eyecare Services

If you have a group medical plan:

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to your group medical plan. You should refer to the plan booklet, certificate of coverage or other benefits description for Your group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Your group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Your COC for additional information regarding COB.)

If You do not have a group medical plan:

When Covered Person does not have a group medical plan, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. You contact a VSP Preferred Provider and make an appointment.

2. You pay the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

Referrals

If Covered Services cannot be provided by Your Preferred Provider, the doctor will refer the You to another Preferred Provider or to a physician whose offices provide the necessary services.

If You require services beyond the scope of the Plan, the VSP Preferred Provider will refer You to a physician.

Referrals are intended to ensure that You receive the appropriate level of care for Your presenting condition. You are not required to get a referral from a Preferred Provider in order to obtain Plan Benefits.

Plan Benefits – Preferred Providers

Covered Services

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of $20.00.
Special Ophthalmological Services: Covered in Full
Eye and Ocular Adnexa Services: Covered in Full

There are no Supplementary Primary Eyecare Plan benefits if you visit an Open Access Provider.

Exclusions and Limitations of Plan Benefits

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Your group medical plan. A current list of the covered procedures will be made available to You upon request.

Not Covered

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where Delta Dental is required by law to pay.