DeltaVision®

Notice of 10-Day Right to Examine Policy: If after examining this Policy you are not satisfied with the Policy terms for any reason, you may return the Policy within 10 days of delivery and upon return, we will refund any premiums paid.

DeltaVision®
Individual and Family
Insight – Preferred

NOTE: A Benefit Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage. The Benefit Period is important for calculating your benefits, copayments, benefit frequencies and member costs, if applicable. Your coverage under the Policy will continue unless one of the following events occurs: 1) You fail to make your premium payment when due each month; 2) You become ineligible for coverage under the Policy; 3) You decide to terminate this coverage – ***Delta Dental of Iowa requires at least a 20-day written notice prior to the requested termination;*** 4) We decide to discontinue offering coverage of all similar Policies by giving written notice to you 90 days prior to discontinuation; 5) You use the Policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid; 6) You are no longer a permanent resident of Iowa; 7) You terminate your individual dental plan with Delta Dental of Iowa.

Effective Date: 11/01/2024
Form Number: INDDVInsight Preferred $10/$10 Discount Fit and Follow-up
HDS ID: 9178281
EyeMed ID: Group ID, 1018670

WELCOME TO DELTAVISION®!

DeltaVision® is offered through Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa ("Delta Dental").

INTERPRETING THIS POLICY

It is important that you understand all parts of this Benefits Policy to get the most out of your coverage. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your other Eligible Covered Persons who qualify for coverage under this Policy. *We*, *us*, and *our* refers to Veratrus Benefit Solutions, Inc., DeltaVision and Delta Dental of Iowa.

We will interpret the provisions of this Policy and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this Policy. If any Benefit in this Policy is subject to a determination of vision necessity and appropriateness, we will make that factual determination. Our interpretations and determinations are final and conclusive.

In this Policy we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your coverage, please contact us.

To administer your Benefits properly, there are certain rules you must follow. Different rules appear in different sections of your Policy. We urge you to become familiar with the entire Policy.

DELTAVISION CONTACT INFORMATION

Benefits & Claims Information

Contact Customer Service for questions concerning Benefits and claims payments.

Available Hours:
Monday – Saturday 7:00 AM – 6:00 PM,
Sunday 10:00 AM- 3:00 PM (CST)

Toll-free: 1-888-899-3747

Eligibility & Enrollment Updates

Please contact your Agent or call DeltaVision's Administration Department for address changes, or any other information changes related to eligibility and enrollment.

Available Hours: Monday – Friday 8:00 AM to 4:30 PM (CST)

Toll-free: 1-877-423-3582 extension 3

Provider Locations

For a list of Vision Care Provider locations, Covered Persons may visit the Delta Dental of Iowa website or contact the Benefit and Claims Phone number listed above.

www.deltadentalia.com

TABLE OF CONTENTS

SUMMARY OF BENEFITS CHART

The information on this page summarizes your Benefits and payment obligations. For a detailed description of specific Benefits and Benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of this Policy.

Benefit Frequency Contact Lenses or Lens Exam Frame	 Once every calendar year Once every calendar year Once every calendar year	
Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Exams Exam Dilation Eye Exam Refraction	 $10 Copay $0 $0	 Up to $35 N/A N/A
Lens Single Vision Bi-focal Tri-focal Standard Progressive Lens Premium Progressive Lens Tier 1 Tier 2 Tier 3 Tier 4 **Lenticular** **Other Lens Type**	 $10 Copay (standard plastic) $10 Copay (standard plastic) $10 Copay (standard plastic) $75 Premium Progressive as follows: $95 $105 $120 80% of charge less $120, plus $75 Copay $10 Copay 80% of charge	 Up to $25 Up to $40 Up to $55 Up to $40 Up to $40 Up to $55 N/A
Frame Frame	 80% of Balance over $130	 Up to $65
Lens Options Standard Polycarbonate Standard Plastic Scratch Coating Tint UR Treatment Standard Anti-reflective Coating Premium Anti-Reflective Coating Tier 1 Tier 2 Tier 3 Photochromatic/Transitions Other Lens Options	 $40 Copay $15 Copay $15 Copay $15 Copay $45 Copay Premium Anti-Reflective as follows $57 $68 80% of Retail $75 80% of charge	 N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A
Contact Lenses Contact Lens – Conventional Contact Lens – Disposable Medically Necessary Contacts	 85% of Balance over $130 Balance over $130 $0	 Up to $104 Up to $104 Up to $200
Fit and Follow-up – Discount Standard Premium	 Up to $40 10% discount off retail	 N/A N/A
Non-Scheduled Items Doctor Misc. Material	 80% of Charge	 N/A
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	N/A
One & Sun	For eligible members, 0% of the earned credit	N/A

Benefit Frequencies are determined by calendar year.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

See the SERVICES NOT COVERED and NOTIFICATION/DOCUMENTATION REQUIREMENTS sections of this Policy for additional information.

IMPORTANT INFORMATION

DeltaVision is pleased to bring these important Benefits to you and your eligible Covered Persons. Please read this Benefits Policy, including the SUMMARY OF BENEFITS CHART and all endorsements, if any, carefully so you know and understand your coverage.

WHAT YOU SHOULD KNOW ABOUT IN-NETWORK PROVIDERS

We have contracting relationships with EyeMed Vision Care, our vision partner, to provide DeltaVision Members with access to the EyeMed Insight Network. Contracts with these Providers include payment arrangements which generally result in savings to you or covered persons on your Policy. When you (or individuals covered under your Policy) receive services from vision Providers who are In-Network:

- In-Network Providers agree to accept the amounts negotiated on behalf of us through our vision partner, EyeMed Vision Care.
- In-Network Providers agree to file claims for you.
- We settle claims directly with In-Network Providers. See UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS later in this section.

WHAT YOU SHOULD KNOW ABOUT OUT-OF-NETWORK PROVIDERS

When you receive services from Out-of-Network Providers, you will not receive any of the advantages that our contracts with EyeMed network Providers offer. As a result, when you receive services from Out-of-Network vision Providers, all of the following statements are true:

- We do not have contracting relationships with Out-of-Network Providers and they do not agree to accept our payment arrangement or any other payment arrangement. This means you are responsible for any difference between your Out-of-Network Provider's billed charge and the Allowance or Allowable Expense.
- Out-of-network vision Providers are not responsible for filing your claims.
- We settle claims with you, not Out-of-Network Providers. You are responsible for paying your Provider in full, including any Copay and non-approved charges you may owe. See UNDERSTANDING BENEFITS POLICY VOCABULARY later in this section.

UNDERSTANDING BENEFITS POLICY VOCABULARY

- **Allowance or Allowable Expense** means the amount or percentage available for a single application toward the cost of covered vision services and materials.
- **Aniseikonic Lenses** are lenses specially designed to correct spatial perception when there is a difference in retinal image size of the same object between the two eyes.
- **Benefit or Benefits** means those vision services or procedures that are covered by DeltaVision® under the terms of this Policy as specified in the SUMMARY OF BENEFITS CHART and subject to the exclusions and limitations, terms, and conditions contained in this Benefits Policy.
- **Benefit Period** is the same as a calendar year. It begins on the day your

coverage goes into effect and starts over each January 1. This is true for as long as you have coverage. The Benefit Period is important for calculating the frequency at which benefits are available on this Policy.

- **Copay or Copayment** means the dollar amount or percentage as shown on the SUMMARY OF BENEFITS CHART that the Eligible Covered Person is required to pay directly to an In-Network Provider for a service or product received that is a Benefit under the Policy.
- **Effective Date** means the date your vision coverage begins.
- **Eligible Covered Person** means an individual who has, been accepted by DeltaVision and paid for coverage and the individual's eligible Spouse and/or eligible Child(ren) (see **YOUR POLICY** section in this Policy.)
- **In-Network Provider** means a vision provider who has entered into an agreement with EyeMed for their Insight Network to provide Benefits to Eligible Covered Persons.
- **LASIK** is Laser-Assisted In Situ Keratomileusis, a type of laser eye procedure used to treat various refractive or focusing errors of the eye. LASIK creates a flap that is opened to expose inner corneal tissue for reshaping, thereby eliminating (or reducing) the corneal refractive error and significantly changing the requirement for corrective eyewear.
- **Member** is an Eligible Covered Person.
- **Out-of-Network Provider** means a vision provider who is not an In-Network Provider.
- **Out-of-Network Reimbursement** is the amount that the program is contractually obligated to pay for the covered services submitted by an Eligible Covered Person who received services from an Out-of-Network Provider.
- **PRK** is Photo-Refractive Keratectomy, a type of laser eye procedure used to treat various refractive or focusing errors of the eye. PRK reshapes tissue on the surface of the cornea, thereby eliminating (or reducing) the corneal refractive error and significantly changing the requirement for corrective eyewear.
- **Provider** is any licensed Optometrist, Ophthalmologist and/or dispensing optician.

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

- **Copay or Copayment** is the dollar amount or percentage, as shown on the SUMMARY OF BENEFITS CHART, that the Eligible Covered Person is required to pay directly to an In-Network Provider for a service or product received that is a covered Benefit under the Policy. The Copayment is applied to the contracted fee for Benefits with the In-Network Provider, or to be applied to the amount in excess of the Allowable Expense for covered Benefits, whichever is applicable.

BENEFITS (COVERED VISION PROCEDURES)

Only vision procedures designated as Benefits on your SUMMARY OF BENEFITS CHART are covered under your Policy.

Benefits are subject to the limitations described in the SUMMARY OF BENEFITS CHART and the exclusions outlined in this Policy. We will pay up to the Allowance shown in the SUMMARY OF BENEFITS CHART for Benefits. Eligible Covered Persons will be responsible for any remaining amount.

Some procedures may require documentation before you receive Benefits (refer to section NOTIFICATION/DOCUMENTATION REQUIREMENTS).

Eligible Covered Persons will also be responsible for any vision care products and services that are not Benefits under the Policy regardless of whether the vision care services were provided by an In-Network Provider or an Out-of-Network Provider.

SERVICES NOT COVERED

This Policy does not provide Benefits for vision services listed in this section.

Please note: Even if the service is not specifically listed as an exclusion, it may not be covered under this Policy.

POLICY EXCLUSIONS AND LIMITATIONS

Benefits Are Not Provided For Services or Materials Arising From:

- Aniseikonic Lenses
- Benefits Combined - Benefits may not be combined with any discount, promotional offering or other group Benefits Plans.
- Brand Names - You are not covered for certain brand name vision materials in which the manufacturer imposes a no-discount practice.
- Broken Appointments - You are not covered for any fees charged because of broken appointments.
- Charges for Consultation
- Drugs - You are not covered for prescription, non-prescription drugs, or medicines or therapeutic drug injections.
- Effective Date - You are not covered for services or supplies received before the Effective Date of coverage under this Policy.
- Employment - You are not covered for corrective eyewear required by an Employer as a condition of employment, and safety eyewear unless specifically covered under your Policy.

- Experimental or Investigative - You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.
- Eye Surgery - You are not covered for medical and/or surgical treatment of the eye, eyes, or supporting structures (except as noted on the SUMMARY OF BENEFITS CHART or Notification/Documentation Requirements).
- Government Programs - You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).
- Incomplete Services - You are not covered for vision services that have not been completed.
- Lost, Broken, or Stolen Lenses, Frames, Glasses or Contact Lenses - Lost, broken, or stolen lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.
- Military Service - You are not covered for services or supplies which are required to treat an illness or injury while you are on active status in the military services.
- Orthoptic or Vision Training, Subnormal Aids, and Any Associate Supplemental Testing
- Payment Accountability - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would not be charged.
- Plano Nonprescription Lenses and Nonprescription Sunglasses
- Procedures Not Specifically Covered Under This Policy
- Remaining Balance - Benefit allowances provide no remaining balance for future use within the same Benefit Frequency (Calendar Year)
- Termination Date - You are not covered for treatment received after the coverage termination date of this Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered are to the Eligible Covered Person are within 31 days from the date of such order.
- Timely Benefit Submission - You are not covered for services or supplies submitted more than 365 days after the services were rendered.
- Treatment By Other Than A Licensed Eye Care Provider - You are not covered for services or treatment performed by anyone other than a licensed eye care provider, or his or her employees.
- Two Pair of Glasses in Lieu Bifocals

- **Vision Care Injuries or Disease** – You are not covered for vision care injuries or disease caused by riots or any form of civil disobedience if the Eligible Covered Person was a participant therein; war or act of war or terrorism; injuries sustained while in the act of committing a criminal act, injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.
- **Workers Compensation** – You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your Employer's Workers' Compensation coverage.

NOTIFICATION/ DOCUMENTATION REQUIREMENTS

LASIK and PRK Vision Correction

LASIK and PRK Vision Correction are elective procedures, performed by specially trained Providers. To receive Benefits, Covered Persons must first call 877-5LASER6 for information on the nearest facility and to receive authorization for the discount. Any discount off retail or promotional price for LASIK or PRK vision correction may not always be available from a Provider in your immediate area.

Medically Necessary Contacts

Medically necessary contacts require documentation of medical necessity from the Provider. In-Network Providers should include the required documentation with the claim submission. If service is provided by an Out-of-Network Provider documentation of medical necessity should be included with the claim form submitted by you (see FILING CLAIMS section of this Policy.)

FILING CLAIMS

Once you obtain services, we need to receive a claim to determine the amount of your Benefits. The claim lets us know the services you received, when you received them, and from which Provider. You will need to file a claim only when using an Out-of-Network Provider. All In-Network Providers will submit claims for you.

WHEN TO FILE YOUR CLAIMS

After you obtain services, you should file a claim. Submission of claims should be made within thirty (30) days unless it is not reasonably possible to do so. Claims received more than 365 days after the services were rendered will not be considered for Benefit.

You should file a claim only *after* services are rendered. Do not file for payment before you receive a service. For Out-of-Network claim submissions, you must complete and sign an Out-of-Network claim form and include itemized paid receipts for the services and materials received on the date of service. The complete information should be mailed to the address provided. If you need a claim form or have any questions after reading this section, please contact us or visit our website at *www.deltadentalia.com.* If you must file your own claim, send it to the following address:

DeltaVision
First American Administrators
ATTN: OON Claims
P.O. Box 8504
Mason, Ohio 45040-7111

APPEALING A DENIED CLAIM

Your Initial Request for a Review

If part or all of the services submitted on your claim have been denied, and you think the service should be covered, you or your representative can ask for a full and fair review of that claim. To file for a review, submit a request within 180 days of receiving the notice of Benefit denial, including the reason why you disagree with the claim decision, and any documents, records or any other information related to the claim. The Eligible Covered Person's name, identification number, and the patient's name should be included on all documents.

Our Reply

Within 30 days of receiving your request, we will send you our written decision and indicate any action we have taken. However, when special circumstances arise, we may require 60 days. We will notify you in the event we require additional days.

Reviewing Records

Upon your request, we will provide you free of charge, access to and copies of all documents, records and other information relevant to your claims for Benefits. You can review records that deal with your request from 8:00 a.m. to 4:30 p.m., Central Standard Time, Monday through Friday, at our office in Johnston, Iowa. Since so many records are electronically filed, please call us in advance at the number listed below so we can have copies ready for you.

Send Requests to:

DeltaVision®
First American Administrators
P.O. Box 8504
Mason OH 45040-7111
1-888-899-3747

YOUR POLICY

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your Policy. Your Policy includes any application you submitted to us or to your agent, this Benefits Policy, and any riders or amendments. All of these materials will be treated by us as representations to us upon which we may rely. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

ELIGIBILITY ENROLLMENT REQUIREMENTS

- You must be a resident of Iowa
- All of the same family Members enrolled on the dental plan must be enrolled on the vision plan;
- If you terminate this Policy before the end of the Benefit Period, voluntary or involuntary, you will not be eligible for the policy again for 24 months from the date of the termination.

ELIGIBLE COVERED PERSONS

Eligible Covered Person(s) means any individual who has been enrolled, been accepted by DeltaVision, and paid for coverage and the individual's Eligible Covered Person(s).

- Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa. Your domestic partner may be an Eligible Covered Person. A domestic partner is a person of the same or opposite sex, whom has shared a permanent residence with you for more than one year, is no less than 18 years of age, is not a blood relative any closer than would prohibit legal marriage in Iowa, you do not qualify under common law marriage, and you are not legally married to anyone in the state in which you reside.
- An eligible child can be your natural child, a child placed with you for adoption as of the date of placement for adoption, the date of the issuance of a final decree, upon an interlocutory adoption decree becoming a final adoption decree, whichever occurs first, or a child for whom you have legal guardianship, a stepchild, or a foster child.

WHEN COVERAGE BEGINS

Your coverage under this Policy begins on your Effective Date.

Please note: Before you receive Benefits under this Policy, you have agreed in your application for coverage (or in documents kept by us or your agent) to release any necessary information requested about you so we can process claims for Benefits. You must allow any healthcare Provider or his or her employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your Benefits may be denied.

If you fraudulently use your Benefits or misrepresent or conceal material facts in your application, then we may terminate this Policy.

WHEN COVERAGE ENDS

Your eligibility for coverage will terminate at the end of the month for any of these reasons:

- You become ineligible for coverage under this Policy. See Eligible Covered Persons earlier in this section.
- You decide to discontinue or replace coverage – **DeltaVision of Iowa requires at least a 20-day written notice prior to the request for discontinuation.**
- If your Delta Dental plan is cancelled or terminated for any reason, we will terminate your vision policy at the end of the month following a 30 day notice of termination.
- We decide to discontinue coverage of all similar Policies by giving written notice to you 90 days prior to the discontinuation.

Your coverage may end if any of the following occurs:

- You use this Policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
- You fail to make payments to us when due.

Please note: You, your eligible spouse, or your eligible children are responsible for notifying DeltaVision of a dissolution of marriage, legal separation or a child losing eligibility status.

PREMIUMS

You must pay us in advance of the due date assigned for your Policy. For example, payment must be made prior to the beginning of each calendar month according to your premium payment method chosen.

EVENTS CHANGING COVERAGE

Certain events may require you to change who is covered by this Policy. These events include:

- **Active Duty in the Military** of an eligible child or spouse
- **Appointment as a Legal Guardian** of a child
- **Birth or Adoption** of a child
- **Care of a Foster Child** (when placed in your home by an approved agency)
- **Death**
- **Divorce, Annulment, or Legal Separation**
- **Marriage**
- **Spouse or Child Loses Eligibility for Qualifying Vision Coverage** or Employer or Group Sponsor ceases contribution to qualifying vision coverage. In this case, your eligible spouse and any eligible children previously covered under the prior qualifying vision coverage are eligible for coverage under this Policy.

NOTIFICATION OF CHANGE

You must notify us within 31 days of the date of the event that changes the status of your eligibility except birth or adoption of a child. DeltaVision must be notified within 60 days of the date of the event that changes the status of your eligibility for births or adoptions. You can ask your Agent to help you make this request. If a change to your eligibility is not made within 31 days of an event (except birth or adoption of a child which is 60 days), the person(s) affected may lose important coverage.

NOTICES

Notice to DeltaVision will be considered sufficient if mailed to each party's regular office address. Notices to you, as the Covered Person, will be considered sufficient if mailed to your last known address to notify you regarding changes or termination of your coverage.

AUTHORIZED POLICY CHANGES

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this Policy. This Policy cannot be changed except by:

- *Written amendment* signed by an authorized officer of DeltaVision as shown by payment of the monthly premium.
- *Our receipt of proper notification* that your marital or eligibility status has changed and we receive an appropriate monthly premium in advance, then we will change your coverage to the correct coverage type. See *Types of Coverage* explained earlier in this section.

EFFECTS OF TERMINATION

If your Policy is terminated for fraud, misrepresentation, or the concealment of material facts:

- *We will not pay* for any services or supplies provided after the date the Coverage is terminated.
- We *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- We may, at our option, *declare the Coverage void.*

If your Coverage is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we will stop Benefits the day your Policy is terminated.

OUR RIGHT TO RECOVER PAYMENTS

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

OTHER INFORMATION

Veratrus Benefit Solutions, Inc.'s Liability

In no instance is Veratrus Benefit Solutions, Inc. liable for any conduct, including but not limited to tortuous conduct, negligence, or wrongful acts or omissions by any service Provider or other professional practitioner or their agents or Employees in the provision or receipt of health care. In no instance is Veratrus Benefit Solutions, Inc. liable for services of facilities that, for any reason, are unavailable to you.

Nonassignment

Benefits for covered services in this Policy are for the Eligible Covered Person(s) and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this Policy or rights to payment without our consent will be void.

Governing Law

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws of the State of Iowa. Any action brought because of a claim under this Policy will be exclusively litigated in the state or federal courts located in the State of Iowa and in no other.

Legal Action

No legal or equitable action may be brought against us because of a claim under this Policy, or because of the alleged breach of this Policy, more than two years after the end of the calendar year in which the services or supplies were provided.

INFORMATION IF YOU OR A COVERED PERSON OF YOUR FAMILY IS ENROLLED IN MEDICAID

Assignment of Rights

This plan will provide payment of Benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such Benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment without regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as an Eligible Covered Person of this plan, nor will it affect our determination of any Benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and we have a legal obligation to provide Benefits for those services, then we will make payment of those Benefits in accordance with any state law under which a state acquires the right to such payments.

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

CONTACT INFORMATION

(Claims and Benefits)

1-888-899-3747

DeltaVision Contact Information

(Enrollment and Eligibility)

1-877-423-3582 extension 3

www.deltadentalia.com