

DeltaVision

Welcome!

Your vision program is underwritten by Delta Dental Plan of Ohio, Inc., a nonprofit health-insuring corporation doing business as Delta Dental of Ohio and is administered by VSP. This Certificate, along with your Summary of Vision Plan Benefits, describes the specific benefits of your DeltaVision program and how to use them. If you have any questions about this program, please call VSP’s Customer Service department at 800-877-7195 or access VSP’s website at www.VSP.com.

We look forward to serving you!

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Please read this Certificate together with the Summary of Vision Plan Benefits. The Summary of Vision Plan Benefits lists the specific provisions of your group vision plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

I. DeltaVision Certificate

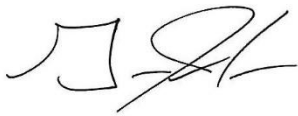
Delta Dental Plan of Ohio, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your vision benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Vision Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Goran M. Jurkovic, CPA, CGMA
President and CEO
Delta Dental Plan of Ohio, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Benefit Authorization

A process used to confirm eligibility of an individual named as a Member and identifying those Benefits to which the Member is entitled.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Vision Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate

will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service.

Copayment

A fixed amount you pay for a Covered.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique vision services selected for coverage as described in the Summary of Vision Plan Benefits and subject to the terms of this Certificate.

Delta Dental

Delta Dental Plan of Ohio, Inc., a nonprofit health-insuring corporation providing dental and vision benefits. Delta Dental is not an insurance company.

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Provider the applicable amount for such service regardless of the Provider's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Vision Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

In-Network Provider/Participating Provider

A Provider who has entered into a contract to be part of the vision care network and to provide Covered Services to Members

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Vision Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Network Provider/Non-Participating Provider

A Provider who has not entered into a contract to be part of the vision care network to provide Covered Services to Members.

Provider

An optometrist, optician or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials in the state or jurisdiction in which vision care services are rendered or vision care materials are provided.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Summary of Vision Plan Benefits

A description of the specific provisions of your group vision coverage. The Summary of Vision Plan Benefits is and should be read as a part of this Certificate and supersedes any contrary provision of this Certificate.

This Plan

The vision coverage established for Members pursuant to this Certificate and your Summary of Vision Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Vision Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

1. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Vision Plan Benefits.
2. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
3. Newborn: Your newborn will be eligible to enroll on the date of birth.
4. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the date that the legal petition for adoption or guardianship becomes legally final, or the date on which

the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.

5. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
6. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Vision Plan Benefits.
7. All others will be permitted on the date that Delta Dental approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Provider

You may choose any Provider. Your out-of-pocket costs are likely to be less if you go to an In-Network Provider.

To verify that a Provider is an In-Network Provider, you can use VSP's online Provider Directory at www.VSP.com or call 800-877-7195.

V. Accessing Your Benefits

To utilize your vision benefits, follow these steps:

1. Familiarizing Yourself with Your Benefits
Read this Certificate and the Summary of Vision Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Obtaining Covered Services from In-Network Providers
To receive Covered Services from an In-Network Provider, You should select an In-Network Provider, schedule an appointment and inform the Provider's office that you are a Covered Person under this Certificate. The In-Network Provider will then obtain a Benefit Authorization prior to the time services are rendered or materials ordered. Delta Dental's claims administrator shall provide a Benefit Authorization to the In-Network Provider. Each Benefit Authorization will contain an expiration date and must be used by the Member to obtain Benefits prior to the date the Benefit Authorization expires. Delta Dental's claims administrator shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Contractor and the past service utilization of the Member, if any. Any Benefit Authorization so issued shall constitute a certification to the In-Network Provider that payment will be made to the In-Network Provider, irrespective of a later loss of eligibility of the Member, as long as the services are rendered or materials provided prior to the Benefit Authorization expiration date. If the Member receives Covered Services from an In-Network Provider without a

Benefit Authorization, any services or materials received from the In-Network Provider will be treated as if they were obtained from an Out-of-Network Provider. You may obtain information on In-Network Providers through VSP's website: www.VSP.com, the Member Service's toll-free number 800-877-7195 or by written request.

3. Obtaining Covered Services from Out-of-Network Providers

This Contract will provide Benefits for services and materials received from Out-of-Network Providers, based on the Out-of-Network Provider fee schedule. The Out-of-Network Provider may bill the Member for that Provider's standard rates, regardless of the amount of this Contract's Benefits. If a Member is eligible for and obtain Benefits from an Out-of-Network Provider, the Member will remain liable for the Out-of-Network Provider's full fee. The Member or the Out-of-Network Provider may submit requests for reimbursement. Delta Dental's claims administrator will pay available Benefits to the Member, or directly to Out-of-Network Providers when claims include a valid Assignment of Benefits. Delta Dental may deny any claims received after 180 calendar days from the date services are rendered and/or materials provided.

4. Submitting a Claim

After you receive your vision treatment, you or the Provider must file a Claim form, completing the information portion with:

- a. The Enrollee's full name and address
- b. The Enrollee's Member ID number
- c. The name and date of birth of the person receiving vision care
- d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most vision offices have Claim forms available. Participating Providers will fill out and submit your vision Claims for you. If you need to file a claim for services rendered by an Out-of-Network Provider, you may do so at www.VSP.com.

Mail Claims and completed information requests to:

**Vision Service Plan
Attention: Claim Services
PO Box 385018
Birmingham, AL 35238-501**

Written Notice of Claim and Time of Payment

All Claims for Benefits must be filed within one year of the date the services were completed. Once a Claim is filed, Delta Dental's claims administrator will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental's claims administrator will notify you or your Provider within 30 days. The notice will describe the information needed. If you or your Provider does

not supply the requested information, Delta Dental's claims administrator will deny your Claim. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental's claims administrator on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, or call the claims administrator toll-free, at 800-877-7195. Delta Dental's claims administrator will only recognize the person whom you have authorized on the last dated form filed. Once you have appointed an authorized representative, Delta Dental's claims administrator will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental's claims administrator will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call our claims administrator's Customer Service department, toll-free, at 800-877-7195, or via email at www.VSP.com.

VI. How Payment is Made

Delta Dental's claims administrator shall make payments for Covered Services in accordance with the plan selected by the Contractor. The Covered Services will be identified on your Summary of Vision Plan Benefits.

VII. Benefits

The Benefits covered by This Plan are set forth in your Summary of Vision Plan Benefits.

Delta Dental agrees to provide Benefits to Members under the policies and procedures of Delta Dental and under the terms and conditions of this Certificate, including, but not limited to, the categories of services, exclusions and limitations listed in the Summary of Vision Plan Benefits.

Covered Services will be subject to the following terms and conditions:

1. Copayments for Covered Services

Any Copayments required under this Contract shall be the personal responsibility of the Member receiving Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed the stated allowances, annual maximum benefits or any other stated limitations are not considered Copayments, but are also the responsibility of the Member.

2. Urgent Vision Care

When vision care is necessary for Urgent Conditions, a Member may obtain such care by contacting an In-

Network Provider or an Out-of-Network Provider (if Out-of-Network benefits are available). Services for conditions of a medical nature are covered by Delta Dental only under supplemental eyecare plans. If Contractor purchases one of these plans, such coverage will be evidenced by an Additional Benefit Rider attached hereto. If Contractor has not purchased one of these plans, then the Member is not covered by Delta Dental for such care and should contact a physician under his or her medical insurance plan for care. For situations of a non-medical nature, such as lost, broken or stolen glasses, a Member may call the Member Service's toll-free number 800-877-7195 for assistance. Reimbursement and eligibility are subject to the terms and conditions of this Certificate.

VIII. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when a Person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100 percent of the total Allowable Expense.

Definitions

Plan

A Plan is any of the following that provides benefits or services for medical or dental or vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

For purposes of this Article VIII, This Plan means, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules

The Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable Expense.

Allowable Expense

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
2. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
3. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement

methodology and another plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.

4. Notwithstanding numbers 1, 2, and 3 above, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan

Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefits Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. Except as provided in paragraph 3 below, a Plan that does not contain a COB provision that is consistent with Ohio regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.
3. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
4. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
5. Each Plan determines its order of benefits using the first of the following rules that apply:
Non-Dependent or Dependent.
The plan that covers the Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
Dependent Child covered under more than one Plan.
Unless there is a court decree stating otherwise, when a dependent Child is covered by more than one Plan the order of benefits is determined as follows:
 1. For a dependent Child whose parents are married or are living together, whether or not they have ever been married:
 - a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), we will follow the rules of that Plan.
 2. For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a. If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - b. If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
 - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child, the provisions of subparagraph (a) above shall determine the order of benefits; or

- d. If there is no court decree allocating responsibility for the dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
 - (1) The Plan covering the Custodial Parent;
 - (2) The Plan covering the spouse of the Custodial Parent;
 - (3) The Plan covering the non-custodial parent; and then
 - (4) The Plan covering the spouse of the non-custodial parent.
- e. For a dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

Active employee or retired employee.

The Plan that covers a person as an active employee, that is, an employee who is not retired, is the Primary Plan. The Plan covering that same person as a retired employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

COBRA or state continuation coverage.

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

Longer or shorter length of coverage.

The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Delta Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the Member, Provider, person or organization that made that payment.

That amount will then be treated as though it were a Benefit paid under This Plan. Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your provider should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-870-9988, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. You may also follow the Claims Appeal Procedure below. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department's website at <http://insurance.ohio.gov>.

IX. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental's claims administrator incorrectly denied all or part of your Claim, you or your Provider may contact Delta Dental's claims administrator and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-877-7195, and speaking to a telephone advisor. You may also mail your inquiry to the claims administrator at VSP, Attn: Appeals Department P.O. Box 2350, Rancho Cordova, CA, 95741.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental's claims administrator provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental's claims administrator to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental's claims administrator informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

**VSP
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741**

Please include your name and address, the Enrollee's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental's claims administrator received it, mail your request certified mail, return receipt requested.

The person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a vision or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a vision health care professional with appropriate training and experience, if necessary. The vision health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 30 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for vision Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a

statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling 614-644-2673 or 800-686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 50 W. Town St., Third Floor, Suite 300, Columbus, Ohio, 43215-4321 or visit the Department's website at <http://insurance.ohio.gov>.

X. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

1. When the Contractor advises Delta Dental to terminate your coverage.
2. On the first day of the month for which the Contractor has failed to pay Delta Dental.
3. For fraud or misrepresentation in the submission of any Claim.
4. For your Dependent, when they no longer qualify as a Dependent.
5. If Delta Dental discontinues the vision product(s) purchased under This Plan or withdraws from the vision market.
6. For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XI. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your vision coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Vision Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.

6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Providers directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed. Please note that Delta Dental's recovery pursuant to this section is subject to your rights as a subrogee as set forth in ORC Section 2323.44

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental and/or its claims administrator with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental and/or its claims administrator access to your vision records.

Provider-Patient Relationship

Members are free to choose any Provider. Each Provider is solely responsible for the treatment and/or vision advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving vision treatment, only Covered Services received while that person was covered under This Plan will be payable.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental's claims administrator within one year following the date the services or supplies were completed.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Vision Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Ohio.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or

circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Insolvency

Delta Dental is not a member of any guaranty fund, and in the event of Delta Dental's insolvency, Enrollees are protected only to the extent that the hold harmless provision required by section 1751.13 of the Ohio Revised Code applies to the health care services rendered.

In the event of insolvency of Delta Dental, an Enrollee may be financially responsible for health care services rendered by a provider or health care facility that is not under contract with Delta Dental, whether or not Delta Dental authorized the use of the provider or health care facility.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street Third Floor-Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than \$100,000 in cash surrender values, \$500,000 in major medical insurance benefits, \$300,000 in disability or long-term care insurance benefits, \$100,000 in other health insurance benefits,

\$250,000 in present value of annuities, or \$300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of \$300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is \$500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act:

For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

**For more information about the Ohio Life & Health Insurance Guaranty Association,
visit our website at: www.olhiga.org.**

As of 11/15/2018

Discrimination is Against the Law.

This plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). This plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

This plan provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). This plan provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator. If you believe this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator at PO Box 9089, Farmington Hills, MI 48333-9089; by phone at 1-800-524-0149 (TTY users call 711). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.