DELTA DENTAL

DeltaVision®
administered by EyeMed

DeltaVision – A vision benefits plan from Delta Dental of Arizona
5656 W Talavi Blvd. Glendale, AZ 85306

This vision policy is underwritten by Delta Dental of Arizona, an Arizona dental and optometric service corporation (Delta Dental). All policies are administered, at least in part, by First American Administrators, Inc. and Renaissance Life & Health Insurance Company of America. . Certain network administration services are provided through EyeMed Vision Care, LLC.

This vision policy should be read in conjunction with the Summary of Covered Services. The Summary of Covered Services included in this policy is an outline of the benefits for your vision policy with Delta Dental of Arizona (Delta Dental). The benefits are subject to all provisions, terms and conditions of the policy.

Your effective date is [xx/xx/xxxx]. The rates per member per month for the plan you selected are listed below and are billed [monthly, annually].

Age Band	Vision 100
Age 0-2	$0.00
Age 3 and over	$9.77

Key Terms and Fine Print You Need to Know

"You", "your" refers to the person who bought this policy. Any information about this policy will come to you. If you did not buy this policy, you will not receive any information from Delta Dental about this policy.

"Member" refers to you and your covered dependents.

This vision policy in conjunction with the Summary of Covered Services, application, and appeals packet constitute the complete vision policy.

This vision policy, which describes the benefit provisions, takes the place of any other vision policy issued to you on a prior date.

This vision policy from Delta Dental of Arizona only covers Arizona residents and is governed by the State of Arizona and applicable to federal law. If you're not an Arizona resident, this policy doesn't cover you.

This policy covers only what it says it covers. This is true even if the service is not expressly excluded in this vision policy. This policy outlines covered services; everything else is not covered, whether or not it is listed as "not covered."

Each enrolled member will be sent an enrollment kit directly from EyeMed Vision Care at the address listed on the enrollment form. The enrollment kit will include ID card(s), benefit information and a listing of contracted Advantage Network providers in your area. Additional ID cards, benefit information look-up and provider listings can be obtained by registering at EyeMed's member website at www.eyemedvisioncare.com or by calling EyeMed's Customer Service Department at 1-866-393-3401.

Notice Of Ten Day Right To Examine Policy

Delta Dental urges you to read this policy carefully and trusts that upon doing so you will fully understand, and will be pleased with, its coverage. If, however, questions arise or information is desired, do not hesitate to consult the selling agent or Delta Dental. In addition, should the policy for any reason be unsatisfactory, by surrendering it within ten (10) days following receipt to our office at P.O. Box 1950, Indianapolis, IN 46206 or to the selling agent, your full vision premium will be refunded, and the policy will be cancelled and deemed void and as never in force and effect

Thank you for selecting Delta Dental for your vision coverage. If we can be of further assistance, please don't hesitate to contact us at 800-294-2961.

Renewal Subject to Consent of Company

DeltaVision

Covered Services Information and Policy Provisions

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Summary of Covered Services

Reimbursement for Vision Care Services is subject to the terms, conditions, exclusions and limitations of this policy. The vision policy provides benefits to eligible members for covered vision services performed in accordance with the laws of Arizona and completed by a person authorized by license to perform such services.

In-Network Provider: when obtaining Vision Care Services from an In-Network provider, you will be required to pay the provider the "Member Cost In-Network" amounts shown below at the time of services. You will not be required to submit a claim form when obtaining services from an In-Network provider.

Out-of-Network Provider: Out-of-Network Provider: when obtaining Vision Care Services from an Out-of-Network provider, you will be required to pay all billed charges to the provider at the time of services unless your provider agrees to accept an assignment of your benefits payable directly from us, in which case you will owe the provider the difference between the amount we pay and the billed charges. Reimbursement either directly to you or to your Out-of-Network provider for covered services is limited to the "Out-of-Network Reimbursement" amounts shown below.

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$30
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	$0 Copay; $130 allowance, 20% off balance over $130	$65
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Standard Progressive	$70 Copay	$40
Premium Progressive	$70 Copay, 80% of charge less $120 Allowance	$40
Lens Options:		
UV Treatment	$12	N/A
Tint (Solid and Gradient)	$12	N/A
Standard Plastic Scratch Coating	$12	N/A
Standard Polycarbonate - Adults	$35	N/A
Standard Polycarbonate - Kids under 19	$35	N/A
Standard Anti-Reflective Coating	$40	N/A
Premium Anti-Reflective	80% of charge	N/A
Polarized	30% off Retail Price	N/A
Other Add-Ons	30% off Retail Price	N/A

Contact Lenses: *(Contact lens allowance includes materials only)* Conventional Disposable Medically Necessary	 $0 Copay, $130 allowance, 15% off balance over $130 $0 Copay, $130 allowance, plus balance over $130 $0 Copay, Paid-in-Full	 $104 $104 $210
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids	Not Covered
Additional Pairs Benefit:	Members also receive a 40% Discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency: Examination Lenses or Contact Lenses Frame	 Once every 12 months Once every 12 months Once every 12 months	

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services or contact lenses.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Members also receive a 40% discount off complete pair prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Plan Limitations and Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by you as a condition of employment, and safety eyewear
- Services provided as a result of any Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof or any services that are provided free except as pursuant to Title XIX of the Social Security Act.
- Plano (non-prescription) lenses
- Non-prescription sunglasses

- Two pair of glasses in lieu of bifocals
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available
- Fees charged by a provider for services other than a covered benefit must be paid-in-full by the insured person; such fees or materials are not covered under the policy

Policy Provisions

Entire Policy and Policy Amendments

This Policy with all amendments and endorsements, the vision summary of covered services, the Appeals Booklet (if applicable), and application constitute the entire Policy between the parties.

No change in this policy will be valid unless it is approved in writing by Delta Dental of Arizona's Chief Executive Officer and given to you for attachment to this policy. No agent has the authority to change this policy or to waive any of its provisions.

Anniversary Date

This policy is written for a period of 12 months from your effective date. You may elect to continue coverage for successive renewal periods by the payment of premiums set by Delta Dental on each renewal date or dis-enroll at any anniversary date.

Limited Assignability of Benefits

A member may not assign or transfer the rights to receive any portion of the benefits to any person or entity except that In-Network providers are paid directly, and if you assign your benefits to an Out-of-Network provider, we will pay the Out-of-Network provider directly on your behalf. See Section "Summary of Covered Services"- Out of Network Provider.

If Delta Dental makes a payment that is inaccurate or makes an overpayment to the member, Delta Dental is entitled to reimbursement from you or may offset the amount owed against a future claim. Inaccurate payments are not a waiver of any future rights of Delta Dental to deny payment for non-covered benefits

Rescission of Coverage

If there is fraud or a material misrepresentation on an enrollment form for coverage for any person ineligible to be covered by the plan, the coverage will be rescinded and will be considered as never having been in effect. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. Delta Dental is entitled to recover the claim payments that exceed the amount of premium paid. The other persons on the benefit plan who remain eligible will not be affected by the rescinded coverage of the ineligible person.

Terminating This Policy

Mid-Term Termination by You

When you buy this policy, you are committing to keeping it in force for at least 12 months. You can terminate this policy sooner only for the following reasons:

A. You become covered under a group vision plan. If anyone else covered under this policy becomes covered under a group plan, they may be terminated without terminating the entire policy.

B. You enter full-time United States military service. If a person covered under this policy other than you enters military service, their coverage may be terminated without terminating the entire policy.

If any of the above events occurred, and you want us to terminate your vision insurance, you must tell us in writing (either electronically or through the mail) at least 31 days in advance of the date you wish to terminate. If you do, we will refund your unused premium.

In the event of your death, anyone else covered under your policy who meets eligibility standards may choose to continue coverage by applying for a new policy. If a covered person other than you dies, you can terminate their coverage without terminating the entire policy.

Mid-Term Termination by Delta Dental
We can terminate your policy before its annual renewal for the following reasons:

A. You don't pay the premium when it's due.
B. You or a covered dependent commits fraud or lies about something having to do with your vision insurance.
C. Someone other than you or a covered dependent uses your vision insurance.
D. You or a covered dependent doesn't comply with the policy or are no longer eligible.

If we terminate your vision insurance, we will refund your unused premium.

Continuation of Coverage for Dependents
If this policy is terminated for a reason other than non-payment of premiums, dependents covered by this policy are entitled to continue coverage under this or a similar policy, provided they meet eligibility requirements. They must submit an application to us and pay the premium within 31 days of termination.

Non-renewal
This policy will automatically renew on an annual basis. If you don't want to renew this policy, send us written notice (either electronically or through the mail) before the policy's renewal date. If you do, this policy will end on the last day before the renewal date. We can non-renew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal date. If we do, this policy will end on the last day before the renewal date.

Effective Date of Termination
All insurance for you and/or other people covered under this policy stops on the date this policy is terminated. That date is:

A. The day following the grace period, if the premium hasn't been paid; or
B. The last day of the month we receive a termination request from you, or any later date stated in your request (if we approve of this date); or
C. The last day before the renewal date if either we or you don't renew this policy; or
D. The last day of the month of the date of your death; or
E. The last day of the month of the date of death of a person covered under this policy other than yourself, but only for that person; or
F. The last day of your current policy period if you move out of Arizona. This applies to anyone covered under this policy.

If your coverage under this policy is terminated for any reason and is not reinstated by us prior to the coverage expiration date, you cannot sign up for another Delta Dental individual policy for 24-months from the date of termination.

Termination for Fraud
If anyone covered under this policy commits fraud or lies about something having to do with your vision insurance, we may terminate your coverage back to its original effective date. If we do that, we'll give back the premium you paid us minus any claims we paid and a reasonable administration fee. If the claims we paid are more than the premium you paid, you must pay us the difference.

Delta Dental's Liability
We are not responsible for the actual care you receive from anyone. This policy does not give anyone any claim, right, or cause of action against us based on what a provider of vision care, services or supplies does or doesn't do.

Eligibility Provisions

Eligible Policyholder
You are covered under this program if you are:

A. A resident in the State of Arizona;
B. At least eighteen (18) years of age; and
C. Concurrently a Policyholder of Delta Dental's Individual and Family dental plans.

Eligible Dependents
If you are enrolled for family coverage, the following dependents may be covered under this policy:

A. Your lawful spouse; and
B. Your legal dependents, married or unmarried, up to the end of the month when they turn age 26 Dependents include newborn children, stepchildren, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with you in accordance with applicable state or federal law
C. Concurrently enrolled as a dependent under the Policyholder's Delta Dental Individual and Family dental plans.

Handicapped Dependents
Your dependent children over age 25 may continue coverage if they are incapable of self-sustaining employment because of physical or intellectual disability that began before the limiting age and are dependent on you for their support and maintenance. Proof of incapacity must be provided to Delta Dental within 31 days of the child reaching the limiting age and subsequently as may be required by Delta Dental, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Coverage for A Newborn/Adopted Child
If you enroll and have family coverage, a newborn child is covered at birth. If you adopt a child, coverage begins the first of the month following the date the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first.

If you do not have family coverage and have any new dependents because of birth, adoption, placement for foster care or placement for adoption, you must complete an application within 31 days for them to be added to the policy on the day they became your dependent. Other dependents not already covered on the policy may also be added. If there is a change in premium, you will be billed for the added dependent(s) as of the effective date.

Adding or Removing Dependents
If you did not include your spouse or dependents at the time you enrolled, they may be added on the policy anniversary date and you must notify us of any necessary change. You will be billed for the added dependent(s) on the bill immediately following the policy anniversary date.

If you have any new dependents because of marriage, you must notify us within 31 days for them to be added to the policy on the first day of the month following the day they became your dependent. Other dependents not already covered on the policy may also be added. If there is a change in premium, you will be billed for the added dependent(s) as of the effective date.

If you wish to remove your spouse or dependents, they may be removed from your policy on the anniversary date. You must notify us of any changes within your renewal period. You may also remove your spouse or dependents within 31 days of a qualifying event. You must notify us of any changes within this time period.

General Provisions

Continuation of Coverage for Dependents
If this policy is terminated for a reason other than non-payment of premiums, the other family members covered by this policy are entitled to continue coverage under this or a similar policy, provided they meet eligibility requirements. They must submit an application to us and pay the premium within 31 days of termination.

Who would not be eligible for conversion coverage?
This conversion coverage is not available to a person covered by other vision benefits, which together with this conversion coverage would constitute duplicate insurance. This coverage also does not apply if the Policyholder terminates the vision Coverage policy as a result of a change to another insurance carrier.

Premiums
Your premium rates for this policy will be shown on page 1. The first month of premium is due with your completed application. You can pay premiums monthly or annually. That time is called a "premium period." Monthly premiums must be set up to pay via Electronic Funds Transfer (EFT) or Credit Card and will be automatically drawn from your account on the 5th day of each month. If your charge is declined, you have a 31-day grace period to make a payment. If at the end of the grace period your account is still overdue, we will cancel your coverage. Annual payments may also be made via paper check and must accompany your completed application.

Any change in premium due to age-band changes will be adjusted on your policy's renewal date. Delta Dental may change the rates and/or benefits under this policy on this policy's renewal date. Notice of changes to the benefit plan and rates will be provided to you 45 days prior to the policy anniversary date.

This policy is valid for 12 months. When you buy this policy, you are committing to keeping it in force for at least 12 months, starting with the policy's effective date as shown on page 1. After that, you can renew this policy for another 12-month period under the following circumstances: if we agree, if you remain eligible, and if premiums are paid according to the procedure described above.

Premium Payment Grace Period
A grace period of thirty one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

Notice of claim
Written notice of claim must be given to Delta Dental within ninety (90) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you to Delta Dental at PO Box 1950, Indianapolis, IN 46206, or to any authorized agent of the Delta Dental, with information sufficient to identify the member, shall be deemed notice to the Delta Dental.

Reinstatement
If any renewal premium is not paid within the time granted to you for payment, a subsequent acceptance of premium by the Delta Dental or by any agent duly authorized by the Delta Dental to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, provided, however, that if the Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Delta Dental or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless the Delta Dental has previously notified you in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects you and Delta Dental shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Claim Payment Provisions

Filing a Claim
Claims should be filed on forms approved by Delta Dental. If the requested forms are not provided within fifteen (15) days after the request is made, the claim may be submitted in a letter which provides written proof of the claim covering the occurrence, the character, and the extent of the loss. The requirements for proof of loss will be considered satisfied if the forms or a written statement as outlined above are received within the time frame as stated in the following paragraph.

Proof of loss means a sworn statement that usually must be furnished by you to Delta Dental before any loss under a policy may be paid. This form is usually used in the settlement of first-party losses and includes the date and description of the occurrence and the amount of loss.

A claim is a demand by an insured or another party for indemnification of a loss under an insurance policy or bond; sometimes, the actual or estimated amount of a loss.

Time Limit on Certain Defenses
A. After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.
B. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Proof of Loss
Written proof of loss must be furnished to Delta Dental at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Delta Dental is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims
Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Provisions Required by Law
Before approving a claim, Delta Dental may receive any information and records for a covered person allowed by law which may be needed to process the claim and will keep such information and records confidential. The release of information is made only to facilitate coverage and in accordance with state and federal laws. If you wish to authorize someone to have access to information, you must give us a written request by sending an Authorization to Disclose Information form. Please call 800-894-2961 to request a form.

Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order, and subject to the confidentiality provisions described above, Delta Dental provides equal parental access to information.

Notice of Decision on Claim
If additional information is needed and, therefore, it is not possible to pay the claim, you will receive a notice within fifteen (15) working days after receipt of the claim. If Delta Dental denies your claim or procedure, or reduces your payment, in whole or in part, including those due to eligibility to participate or utilization review, you will receive an Explanation of Benefits ("EOB") describing your liability for services received. If you do not receive a decision within thirty (30) days after Delta Dental receives information required to process the claim, you will have an immediate right to request a review as if the claim had been denied.

If Delta Dental denies any part of the claim, you will receive a written notice of denial containing:

A. The reasons for the decision;
B. A description of any additional information needed to support the claim; and
C. Information concerning your right to appeal the decision.

Claims Appeal Process
Either you or your treating provider can file an appeal on your behalf. Delta Dental provides a form you can use in the Appeals Packet. You are not required to use the form; a letter with the same information is acceptable. If you decide to appeal a decision to deny authorization or payment of a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

The process for an appeal is described in detail in the Appeals Packet, a separate document, which is provided to you when you become a policyholder. You can request another copy of the Appeals Packet by visiting our website at www.deltadentalaz.com/appeals or calling 800-894-2961 to request a form.

Legal Actions
No action at law or in equity may be brought by you on a claim until sixty (60) days after you have given us proof of loss. No such action may be brought more than three years after the end of the period within which proof of loss must be provided.

Examination
Delta Dental may investigate your claims at any time. Delta Dental at its own expense shall have the right and opportunity to examine the covered person and/or review treatment histories when and as often as it may reasonably require during the pendency of a claim hereunder. Delta Dental may deny or suspend payment of vision benefits if the covered person or the vision provider fails to cooperate with a review or examination by the vision professional that Delta Dental selects.

Claims Payment After Policy Termination
Delta Dental will not pay for any claim prior to the termination date but submitted by you or your provider more than twelve (12) months after the date of a member's termination. Delta Dental is not required to pay benefits for claims provided after the cancellation date.

Notices
Any notice sent to Delta Dental must be sent in writing (either electronically or through the mail). It's considered delivered when sent to us at the email address shown below; when given in person; or when sent registered or certified United States mail, return receipt requested, proper postage prepaid, and properly addressed to:

Delta Dental
Attn: Individual Product Unit
P.O. Box 1950
Indianapolis, IN 46206
Email: service@smilepoweraz.com

Information sent to you will be considered sufficient if sent to your last known physical address or email address.

Governing Law
This policy is issued and delivered in the State of Arizona and obeys its laws and regulations. If it conflicts with any of Arizona's laws and regulations, it will automatically conform to the state's minimum requirements.

Nonwaiver and Severability
If we don't exercise any remedy or right under this policy, that doesn't affect our ability to exercise any remedy or right at any time in the future.

Problems with Your Insurance
If you have problems with any insurance company or agent, contact them to resolve your problem. You can contact Delta Dental at the following address and telephone number:

Delta Dental
Attn: Individual Product Unit
P.O. Box 1950
Indianapolis, IN 46206
800-894-2961