DELTA DENTAL®

DeltaVision® Benefits Certificate

$150 Frame Allowance / $15 Lens Copay

Insight Network

Effective Date: 07/2024
Form Number: 1010684-105
HDS ID Number: 13035945
Voluntary or Contributory

WELCOME TO VERATRUS BENEFIT SOLUTIONS, INC.

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

It is important that you understand all parts of this Benefits Certificate (Certificate) 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 eligible Covered Persons who qualify for coverage under this Certificate. *We*, *us*, and *our* refers to Veratrus Benefit Solutions, Inc.

We will interpret the provisions of this Certificate 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 Certificate. If any Benefit in this Certificate 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 Certificate 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 Certificate. We urge you to become familiar with the entire Certificate.

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 Employer or Group Sponsor or call DeltaVision's Group 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: 1-877-983-3582

Provider Locations

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

www.deltadentalia.com/deltavision

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SUMMARY OF BENEFITS CHART

The information on this page summarizes your Benefits and payment obligations.

Benefit Frequency		
Contact Lenses or Lens	Once every calendar year.	
Exam	Once every calendar year.	
Frame	Once every two calendar years.	
Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Exam		
Exam	$10 Copay	Up to $35
Dilation	$0	N/A
Eye Exam Refraction	$0	N/A
Lens		
Single Vision	$15 Copay	Up to $25
Bi-focal	$15 Copay	Up to $40
Tri-focal	$15 Copay	Up to $55
Standard Progressive Lens	$75 Copay	Up to $40
Premium Progressive Lens	Premium Progressive as follows:	Up to $40
Tier 1	$95	
Tier 2	$105	
Tier 3	$120	
Tier 4	80% of Balance less $120, plus $75 Copay	
Lenticular	$10 Copay	Up to $55
Other Lens Type	80% of Charge	N/A
Frame		
Frame	80% of Balance over $150	Up to $75
Lens Options		
Standard Polycarbonate	$40 Copay	N/A
Standard Plastic Scratch Coating	$15 Copay	N/A
Tint	$15 Copay	N/A
UV Treatment	$15 Copay	N/A
Standard Anti-reflective (a/r) Coating	$45 Copay	N/A
Premium Anti-reflective (a/r) Coating	Premium Anti-reflective Coating as follows:	
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of Retail	N/A
Photochromatic/Transitions	$75	N/A
Other Lens Options	80% of Charge	N/A
Contact Lenses		
Contact Lens --- Conventional	85% of Balance over $150	Up to $120
Contact Lens --- Disposable	Balance over $150	Up to $120
Medically Necessary Contacts	$0	Up to $200
Fit and Follow-Up Discount		
Standard	$40	N/A
Premium	10% off retail price	N/A
Non-Scheduled Items		N/A
Doctor Misc. Materials	80% of Charge	
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	N/A

Benefit Frequencies are determined by calendar year
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency

SEE SECTION ON SERVICES NOT COVERED AND NOTIFICATION/DOCUMENTATION REQUIREMENTS FOR ADDITIONAL INFORMATION

IMPORTANT INFORMATION

DeltaVision has been selected by your Employer to provide your group vision coverage. We are pleased to bring these important Benefits to you and your eligible Covered Persons. Please read this Benefits Certificate, including the SUMMARY OF BENEFITS CHART and all endorsements, if any, carefully so you know and understand your coverage

UNDERSTANDING BENEFITS CERTIFICATE 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 your Employer's Contract as specified in the SUMMARY OF BENEFITS CHART and subject to the exclusions, terms, and conditions contained in this Benefits Certificate.
- 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 contract.
- Effective Date means the date your vision coverage begins.
- Eligible Covered Person is an Employee who has met the Employer's eligibility requirements and the Employee's eligible spouse and/or eligible child(ren).
- Employee means an individual actively employed by the Employer for purposes of Social Security laws or who otherwise is included as a member of staff as required by law (or a member of the Board of Directors of an Employer).
- Employer or Employer Group or Group Sponsor is the particular employing individual, agency, corporation, partnership, or company, or that particular association or trust which has entered into this agreement to provide vision coverage to its Eligible Employees or Eligible Members and is responsible for appointing a Plan Administrator for the Group Vision Program.
- In-Network Provider means a vision care Provider who has entered into an agreement 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.
- Out-of-Network Provider" means a vision care 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.

- Plan Administrator means the Employer Group (or the individual(s) designated by the Employer Group) who maintains the Plan under which these Benefits are provided.
- 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 contract. 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.

HELPING WHEN YOU HAVE QUESTIONS

If you have any questions about your Benefits after reading this Certificate, you may contact us.

BENEFITS (COVERED VISION PROCEDURES)

Only vision procedures designated as Benefits on your SUMMARY OF BENEFITS CHART are covered under your Group's contract.

Benefits are subject to the limitations described in the SUMMARY OF BENEFITS CHART and the exclusions outlined in this DeltaVision Certificate. 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 contract regardless of whether the vision care services were provided by an In-Network Provider or an Out-of-Network Provider.

SERVICES NOT COVERED

This DeltaVision Certificate 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 Certificate.

Certificate 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 Certificate.
- 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 plan.
- 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 Certificate, you would not be charged.

- Plano Nonprescription Lenses and Nonprescription Sunglasses

- Procedures Not Specifically Covered Under This Contract

- 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 Certificate, 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 person(s) 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.)

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/deltavision.* If you must file your own claim, send it to the following address:

DeltaVision
ATTN: OON Claims
P.O. Box 9010
Johnston, Iowa 50131-9010

Coordination of Benefits

Coordination of Benefits (COB) applies when a Covered Person has vision care coverage under more than one plan. The COB rules determine which plan will pay as the primary plan. The primary plan pays first without regard to any other vision care coverage that is also in effect. A secondary plan pays after the primary plan, and Benefits may be reduced so that payments from all group plans do not exceed 100% of the total Allowable Expense. Your DeltaVision plan considers itself the primary plan, and will coordinate as the secondary plan if you submit a claim that indicates another plan has already paid as the primary plan.

What Should You Do
When you receive vision services, you need to let your provider know if you have other coverage. Other coverage includes:

- group insurance
- other group coverage (such as HMOs, PPOs, and self-insured programs)
- Medicare or other governmental coverage
- and the medical coverage in your automobile insurance (whether issued on a fault or no-fault basis).

To help us coordinate your Benefits, you should:

- Inform your Provider by giving him or her information about your other coverage at the time you receive services.
- You or your provider should send a claim form to us along with an Explanation of Benefits (EOB) from your primary plan.

What We Will Do
Coordination of Benefits is complicated. There are certain rules we follow to help us determine which benefit plan pays first when you have other coverage that provides the same or similar benefits as this Certificate. We will use the COB guidelines adopted by the Iowa Insurance Division to determine the payment to you or your provider.

If you have any questions about your Coordination of Benefits, contact us at:

DeltaVision
ATTN: Claims
P.O. Box 9010
Johnston, IA 50131-9010

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 so we can have copies ready for you.

Send Requests to:

DeltaVision
ATTN: Quality Assurance Dept.
P.O. Box 9010
Johnston, IA 50131-9010

Your Certificate

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any application you submitted to us or to your Employer or Group Sponsor, any agreement or group policy we have with your Employer or Group Sponsor, any application completed by your Employer or Group Sponsor, this Benefits Certificate, and any riders or amendments. All of the statements made by your Employer or Group Sponsor or you in any 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.

Eligible Covered Persons
An Eligible Covered Person is an Employee who has met the Employer's eligibility requirements and the Employee's eligible spouse and/or eligible child(ren).

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa. An eligible child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. Children must meet at least one of the following standard requirements to be an eligible child:

- The child is under age 26.
- The child is age 26 or older not married and a full-time student. For an eligible child to be considered a full-time student they must be enrolled in an accredited institution of higher learning, such as a college, university, nursing, or trade school, and carry enough hours to be classified by the institution as full-time. Full-time student status continues during regularly scheduled school vacation periods, and during absence from class in which enrolled for up to four months due to a physical or mental disability. Veratrus Benefit Solutions, Inc. may require the disability be substantiated by a written statement from a physician.
- The child is a dependent of the child's parent and is totally or permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student under 26 years of age, and the dependent child must have had continuous qualifying vision coverage without a break of 63 days or more since the child turned age 19 or while the child was a full-time student under age 26.
- A child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

LATE ENTRANT AND RE-ENROLLMENT PROVISIONS
If you decline coverage (for yourself or your eligible Covered Persons) when you are initially eligible as determined by your Employer Group's enrollment guidelines, you are not eligible for this coverage except as follows:

- During a subsequent anniversary date of the contract between us and your Employer or special enrollment period determined by your Employer Group.
- If a qualifying event occurs as listed under EVENTS CHANGING COVERAGE.

- If you terminate this coverage, for whatever reason, you are not eligible to re-enroll at a later time unless you have a qualifying event or during a subsequent anniversary date of the contract between us and your Employer Group or special enrollment period determined by your Employer Group.

TYPES OF COVERAGE

There are different categories of coverage you may hold under this Certificate:

- With *Single coverage*, you are the only one covered.
- With *Family coverage*, you, your eligible spouse, and each of your eligible children are covered. Each eligible Covered Person must be listed on your vision application for coverage or added later following a qualifying event.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If you have a child and your Employer receives a Medical Child Support Order recognizing the child's right to enroll in this Benefit plan, your Employer will promptly notify both you and the child that the order has been received. Your Employer also will inform you and the child of the Employer's procedures for determining whether the order is a Qualified Medical Child Support Order. You may obtain, without charge, a copy of QMCSO procedures from your Employer or Group Sponsor.

WHEN COVERAGE BEGINS

Your coverage under this Certificate begins on your Effective Date. If you have just started a new job, check with your Employer or Group Sponsor to determine your Effective Date.

Please note: Before you receive Benefits under this Certificate, you have agreed in your application for coverage (or in documents kept by us or your Employer or Group Sponsor) 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 Certificate.

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 Certificate. See *Eligible Covered Persons* earlier in this section.
- You become unemployed. Termination of your Certificate for this reason applies only if you receive your coverage through your Employer or Group Sponsor.
- Your Employer or Group Sponsor decides to discontinue or replace this coverage.
- We decide to terminate coverage of all similar Certificates by giving written notice to your Employer or Group Sponsor 90 days prior to termination.

Your coverage may end if any of the following occurs:

- You use this Certificate 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 or your Employer or Group Sponsor fail to make payments to us when due.

AUTHORITY TO TERMINATE, AMEND, OR MODIFY

Your Employer or Group Sponsor has the authority to *terminate, amend or modify the coverage described in this Certificate at any time.* Any amendment or modification will be in writing and will be as binding as this Certificate. *If your contract is terminated, you may not receive Benefits.*

CONTINUED COVERAGE (COBRA)

There are some federal and state laws that may affect your coverage with us. These laws apply to continuing your coverage when you are no longer eligible for group coverage.

Coverage Continuation Under Federal Law - COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to Employers with 20 or more Employees. COBRA entitles you, your eligible spouse, and your eligible child(ren) to a continuation of coverage under this Certificate if coverage is lost due to any of the following qualifying events:

- Death of the Employee covered under this Certificate.
- Termination of employment for reasons other than gross misconduct.
- A reduction in hours causing loss of Coverage.
- Divorce or legal separation.
- The Employee covered under this Certificate becomes entitled to Medicare.
- Child/Children no longer considered eligible by our eligibility rules.
- The Employer, from whom the covered Employee retired, files bankruptcy under federal law (in certain cases).

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

If you wish to continue your coverage, you must complete an election form and submit it to your Employer within 60 days of the later of the date:

- you are no longer covered; or
- you are notified of the right to elect COBRA continuation coverage.

You will be responsible for paying any premiums to your Employer for the continuation of this Certificate. Depending on how you qualify, you may continue your coverage for up to 18 or 36 months.

If during the period of COBRA coverage, a child is born to you or placed with you for adoption, the child can be covered under COBRA coverage and can have election rights of his or her own.

If you or any other eligible Covered Person(s) who have elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you, your eligible spouse and/or eligible child(ren) who elected COBRA coverage. You must provide notice of the disability determination to your Employer within 60 days after the determination.

If you lose your coverage, contact your Employer or Group Sponsor. They should help you with any necessary paperwork and let you know the cost of continuing your coverage.

Length of Coverage under COBRA
Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable.
- The first day (including grace periods, if applicable) on which timely payment is not made.
- The date on which the Employer ceases to maintain any group plan (including successor plans).
- The first day on which a beneficiary is actually covered by any other group plan. However, if the new group plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group plan or upon the occurrence of any one of the other events stated in this section.
- The date the qualified beneficiary is entitled to Medicare Benefits.

Premiums
You or your Employer or Group Sponsor must pay us in advance of the due date assigned for your Certificate. For example, payment must be made prior to the beginning of each calendar month.

Events Changing Coverage
Certain events may require you to change who is covered by this Certificate. 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).
- Completion of Full-time Schooling of an eligible child age 26 or older
- Death
- An Eligible Child (who is *not* a full-time student or permanently disabled) reaches age 26
- Divorce, Annulment, or Legal Separation
- Exhaustion of COBRA Coverage
- 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 Certificate.

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 Employer or Group Sponsor 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 your Employer or 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 or the last known address of your Group. It is the responsibility of your Group to notify you regarding changes or termination of your coverage.

AUTHORIZED CERTIFICATE 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 Certificate. This Certificate cannot be changed except by:

- *written amendment* signed by an authorized officer and accepted by you or your Employer or Group Sponsor 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 Certificate 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 Coverage is terminated.

OUR RIGHT TO RECOVER PAYMENTS

If for any reason we make payment under this Certificate 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 Certificate are for the Eligible Covered Person(s) and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this Certificate 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 Certificate 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 Certificate 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 Certificate, or because of the alleged breach of this Certificate, 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)

1-877-983-3582

www.deltadentalia.com/deltavision

DELTA DENTAL

DeltaVision® Benefit Certificate Rider

DeltaVision Diabetic Eye Care Benefit

Your DeltaVision® Benefit Certificate ("Benefit Certificate") is amended as described in this document. This DeltaVision Diabetic Eye Care Benefit Rider ("Rider") becomes a part of your Benefit Certificate and is subject to all provisions of your Employer's Contract. This Rider provides the DeltaVision Diabetic Eye Care Benefit to Employer Group customers who have elected the benefit. Benefits provided by this Rider may be subject to payment of additional premiums.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Benefit Certificate or in this Rider.

When we use the words "we," "us," and "our" in this document, we are referring to Veratrus Benefit Solutions, Inc. ("VBS"). When we use the words "you" and "your," we are referring to people who are Eligible Covered Persons, as the term is defined in this Rider.

You are encouraged to read this Rider and keep it with your Benefits Certificate.

Definition:

- Eligible Covered Person ("Covered Person") - For purposes of this Rider only, a Covered Person is an employee who has met the employer's eligibility requirements and the employee's eligible covered spouse and children.

Delta Vision Diabetic Eye Care Benefit:

The DeltaVision Diabetic Eye Care benefit is designed to help detect and minimize vision-related complications by providing access to more frequent and in-depth eye care. It includes:

- Coverage for Covered Person(s) with Type 1 or Type 2 diabetes
- An office visit and diagnostic testing once every six months (separate from a comprehensive eye exam)
- Diagnostic testing such as gonioscopy, extended ophthalmoscopy, fundus photography, and scanning laser (offered at the provider's discretion)

Exclusions and Limitations:

The DeltaVision Diabetic Eye Care Benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:

- Costs associated with securing frames, lenses or any other materials
- Orthoptics or vision training and any associated supplemental testing
- Surgical procedures, including laser or any other form of refractive surgery and any pre- or post-operative services
- Pathological treatment of any type for any condition
- Any eye examination required by an employer as a condition of employment
- Insulin or any medications or supplies of any type
- Services and/or materials not included in this Rider

How to contact us:

If you have questions about this benefit, please contact us at [number].