Delta Vision in Partnership with VSP

GROUP VISION CARE INSURANCE CERTIFICATE

Underwritten by:	Delta Dental of Tennessee 240 Venture Circle Nashville, TN 37228
Administrator:	Vision Service Plan Insurance Company (VSP) 240 Ventura Circle Nashville, TN 37228

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown on the Certificate Schedule page.

This Policy sets forth the benefits provided, subject to the exceptions, limitations and exclusion listed. This Policy is delivered in and governed by the laws of the state of Tennessee This Policy is subject to terms and conditions recited on the following pages including any Attachments.

Phil Wenk, President & CEO

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

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PART I. CERTIFICATE SCHEDULE

Policyholder:	Vanderbilt University
Group Policy Number:	V7831-1000G3
Effective Date:	January 1, 2021
Initial Term:	36 Months from Initial Effective Date
Eligible Classes:	All full-time employees working at least 30 hours per week
Waiting Period:	Date of hire
Mode of Premium Payment:	Monthly
Method of Premium Payment:	Remitted by Policyholder
Premium Due Date:	1st of every month

PART II. SCHEDULE OF BENEFITS

FREQUENCY OF SERVICES	
Vision Exam:	Once every 12 Months
Eyeglass Lenses:	Once every 12 Months
Frames:	Once every 24 Months
Contact Lenses:	Once every 12 Months
Contact Lens Fit:	Once every 12 Months

CO-PAY (PER INSURED)		
	In-Network Providers	**Out-of-Network Provider**
Vision Exam	$10	See Benefits and Allowances
Eyeglass Lenses/Frames	$25	
Contact Lens Fit	Up to $60	

BENEFITS AND ALLOWANCES [1]		
	In-Network Providers	**Out-of-Network Provider**
Vision Exam	$10	Up to $45 Allowance
Materials- Eyeglass Lenses[2]		
Single Vision	Covered in Full	Up to $30 Allowance
Progressive (Standard)	Covered in Full	Up to $50 Allowance
Bifocals	Covered in Full	Up to $50 Allowance
Trifocals	Covered in Full	Up to $65 Allowance
Lenticular	Covered in Full	Up to $100 Allowance
Materials – Frames[2]	$130 Allowance	Up to $70 Allowance
Materials – Contact Lenses[2]		
Non-Elective[3]	See the Certificate of Coverage	Up to $210 Allowance
Elective	See the Certificate of Coverage	Up to $105 Allowance

1 Where an "Allowance" is shown, you are responsible for paying any charges more than the Allowance.

2 Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit. Contact Lenses Benefit is paid in lieu of the Eyeglass Lenses and Frames.

3 Medically necessary contact lenses are covered in full less any applicable co-pays.

PART III. DEFINITIONS

ADDITIONAL BENEFIT RIDER: The document, attached as Exhibit C to this Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under this Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under Exhibit A.

ADMINISTRATOR: The entity designated by Delta Dental to administer the Plan Benefits described in this Policy. Currently the Administrator is Vision Service Plan Insurance Company ('VSP").

ASSIGNMENT OF BENEFITS: A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing Delta Dental to pay available Plan Benefits to a named Open Access Provider.

BENEFIT AUTHORIZATION: A process used to confirm eligibility of an individual named as a Covered Person of DeltaVision, and identifying those Plan Benefits to which Covered Person is entitled.

CLIENT: An employer or other entity which contracts with Delta Dental to provide coverage under this Policy for its Enrollees and their Eligible Dependents.

CLIENT APPLICATION: The form signed by an authorized representative of the Client to apply for Enrollee coverage under this Policy.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985.

COMPLAINTS AND GRIEVANCES: Disagreements regarding access to care, quality of care, treatment, or service.

CONFIDENTIAL MATTER: All confidential information concerning the medical, personal, financial, or business affairs of Covered Persons acquired by Delta Dental in the course of providing Plan Benefits hereunder.

COORDINATION OF BENEFITS: A procedure which allows more than one insurance plan to consider a Covered Person's vision care claims for payment or reimbursement.

COPAYMENTS: Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

COVERED PERSON: An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to Delta Dental, and who is covered under this Policy.

DELTA DENTAL: Delta Dental of Tennessee ("Delta Dental") a Tennessee not-for-profit dental services corporation, or its designated Administrator.

DELTAVISION™: The vision products and plans underwritten by Delta Dental.

ELIGIBLE DEPENDENT: Any dependent of an Enrollee who meets the criteria for eligibility established by Client.

ENROLLEE: An employee or member of Client who meets the criteria for eligibility established by Client.

CERTIFICATE OF COVERAGE ("COC"): A summary of the provisions of this Policy prepared by Delta Dental and provided to Client for distribution to Enrollees by Client.

OPEN ACCESS PROVIDER: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with Delta Dental to provide vision care services and/or vision care materials to Covered Persons of Delta Dental.

PLAN or PLAN BENEFITS: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.

POLICY PERIOD: The length of time this Policy is in effect, as shown on the front page of this Policy.

RENEWAL DATE: The date when this Policy shall renew or terminate if proper notice is given.

RETENTION: Delta Dental's administrative fee deducted from net premiums paid by Client.

RISK PROGRAM: A fully insured vision care plan whereby Delta Dental will calculate a rate per Enrollee to cover the cost of claims incurred and administrative costs. Under the arrangement, Delta Dental assumes the risk of utilization exceeding the rate per Enrollee over the full Policy Term.

SCHEDULE OF BENEFITS: The document, attached as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

SCHEDULE OF PREMIUMS: The amounts described in the Declaration Page attached to this Policy, which defines the payments a Client is obligated to pay to Delta Dental on behalf of a Covered Person to entitle him/her to Plan Benefits.

STATE OF DELIVERY: The State in which this Policy is being issued, delivered, or renewed.

TERMINATION: Cancellation of the Policy as stated in Article I.

URGENT CONDITION: A condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

VISION CARE POLICY or POLICY: The Policy issued by Delta Dental to a Client, under which the Client's Enrollees or members, and their Eligible Dependents, are entitled to become Covered Persons of DeltaVision and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.

PREFERRED PROVIDER: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with Delta Dental to provide Plan Benefits to Covered Persons of DeltaVision.

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

BLEPHARITIS Inflammation of the eyelids.

CATARACT A cloudiness of the lens of the eye obstructing vision.

CONJUNCTIVA The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.

CONJUNCTIVITIS	See Pink Eye.
CORNEAL ABRASION	Irritation of the transparent, outermost layer of the eye.
CORNEAL DYSTROPHY	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
DIPLOPIA	The observance by a person of seeing double images of an object.
EYECARE PROFESSIONAL	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
EYE MUSCLE DYSFUNCTION	A disorder or weakness of the muscles that control the eye movement.
FLASHES OR FLOATERS	The observance by a person of seeing flashing lights and/or spots.
GLAUCOMA	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
MACULA	The small, sensitive area of the central retina, which provides vision for fine work and reading.
MACULAR DEGENERATION	An acquired degenerative disease which affects the central retina.
OCULAR	Of or pertaining to the eye or the eyesight.
OCULAR CONDITIONS	Any condition, problem or complaint relating to the eyes or eyesight.
OCULAR HYPERTENSION	Unusually high blood pressure within the eye.
OCULAR TRAUMA	A forceful injury to the eye due to a foreign object.
PINK EYE	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
RETINAL NEVUS	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
SYSTEMIC CONDITION	Any condition of problem relating to a person's general health.
STY	An inflamed swelling of the fatty material at the margin of the eyelid.
TRANSIENT LOSS OF VISION	Temporary loss of vision.

PART IV. ELIGIBILITY AND ENROLLMENT OF SUBSCRIBERS AND DEPENDENTS

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

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

Dependents in military service are not eligible.

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

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

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

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

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

PART V. CHOOSING A PREFERRED PROVIDER

A preferred provider, referred to in this Policy as a "Preferred Provider," is an optometrist or ophthalmologist that has signed a contract with VSP to provide Plan Benefits to You under Delta Dental policies. Each Preferred Provider has agreed to accept discounted fees as payment from VSP in exchange for being listed in its directory of its contracting doctors. A doctor who is not a Preferred Provider has no contractual arrangement with Delta Dental or VSP and can charge whatever fee he or she desires. You can obtain more information regarding preferred providers, including a list of doctors in your area, by visiting the web site listed on the Benefit Summary Page. You may also call VSP Customer Care.

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

PART VI. HOW TO USE THIS PLAN

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

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

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

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

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

Urgent Vision Care

Services for conditions of a medical nature are covered by Delta Dental only under specific supplemental eye care Plans purchased by the group. If the group purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, You may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for You to obtain vision care for Urgent Conditions of a medical nature. If the group has not purchased one of these plans, You are not covered by Delta Dental for medical services and should contact a physician under Your medical insurance plan for care.

Coordination of Benefits

The following rules are used to determine coordination of benefits. When Delta Dental is the primary insurer, it will pay benefits according to the terms of this Policy. Some state or federal codes, statutes or regulations may apply. When Delta Dental is the secondary insurer, it will coordinate those vision care services and materials that were considered by the primary insurer as allowable expenses. Delta Dental will pay the lesser of:

a) The normal Plan Benefit, in the absence of other coverage, or
b) The remaining balance up to Covered Person's Plan Benefits, not to exceed the billed amount.

PART VII. GENERAL PROVISIONS

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

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

C. If you or your covered dependent has two vision care coverages, VSP will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.

1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
2. Where the patient is a dependent child, primary coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary.

3. If there is a court decree stating that one parent has financial responsibility for a child's vision care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

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

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

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

PART VIII. BENEFITS

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

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

Exclusions and Limitations of Benefits
Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. You may obtain details regarding frame brand availability from your VSP Preferred Provider. You may also call VSP's Customer Care.

Not Covered
- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Sun care enhancement, if purchased by Group.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where Delta Dental is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

PART IX. SCHEDULE OF BENEFITS

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

Plan Benefits – Preferred Providers

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

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

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

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

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

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

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

Plan Benefits – Open Access Providers

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

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

Lenses - Single Vision: Up to the plan allowance
Bifocal: Up to the plan allowance
Trifocal: Up to the plan allowance
Lenticular: Up to the plan allowance

Frames - Covered up to the plan allowance

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

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

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

PART X. ADDITIONAL BENEFIT RIDER – SUPPLEMENTAL PRIMARY EYECARE PLAN

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

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

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

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

- ocular discomfort or pain
- onset of eye muscle dysfunction
- transient loss of vision
- pain in or around the eyes
- ocular trauma
- swollen lids

- ocular foreign body sensation
- flashes or floaters
- diplopia
- red eyes

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

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

Procedures for Obtaining Supplemental Primary Eyecare Services
If you have a group medical plan:

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

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

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

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

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

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

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

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

Plan Benefits – Preferred Providers

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

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

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

Not Covered

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

PART XI. COMPLAINTS AND GRIEVANCES

Complaints and grievances may be submitted by Covered Persons to Delta Dental in writing, by telephone, online or through Covered Persons' Preferred Providers, The COC explains this process. Delta Dental will resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. If such extension is required, Delta Dental will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If Delta Dental determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. Delta Dental will notify Covered Person in writing of the final resolution of all complaints and grievances.

PART XII. CLAIM DENIAL APPEALS

If a claim is denied in whole or in part, under the terms of this Policy, a request may be submitted to Delta Dental by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. The Covered Person may review, during normal business hours, any documents held by Delta Dental pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in Delta Dental's review. Delta Dental's response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Delta Dental within sixty (60) calendar days after receipt of Delta Dental's response to the initial appeal. Delta Dental shall communicate its final determination to Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Delta Dental's communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and Covered Person disagrees with the outcome of such appeals.

Time of Action
No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Delta Dental. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

Insurance Fraud
Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

PART XIII. CONTINUATION OF COVERAGE

COBRA
If, and only to the extent, COBRA applies to the parties to this Policy, Delta Dental shall make the required COBRA continuation coverage available to Covered Persons in accordance with the provisions of COBRA.

Replacement Coverage
Delta Dental reserves the right to offer replacement Delta Dental coverage to individuals whose previous Delta Dental coverage has terminated or is subject to termination. Any such offer of replacement coverage shall be separate and distinct from, and not in lieu of, any COBRA-required offer of continuation coverage.

PART XIV. DISPUTE RESOLUTION

Delta Dental and Client agree that all disputes relating to this Policy shall be resolved, wherever possible, through mediation. When such negotiation is not successful, both parties agree to try in good faith to settle disputes by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures. All efforts shall be made by both parties to avoid arbitration, litigation, or other dispute resolution procedures.

Choice of Law
If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Tennessee shall be the applicable law.

PART XV. NOTICES

Any notices required under this Policy to either Client or Delta Dental shall be in written format. Notices sent to the Client will be sent to the address or email address shown on the Client's Application. The Client may choose a different address for Notices. Notices to Delta Dental shall be sent to the address shown on the front page of this Policy. Notices may be hand-delivered by either party to an appropriate representative of the

other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

PART XVI. STANDARD PROVISIONS

Entire Agreement
This Policy, the Client Application, the Certificate of Coverage, and all Exhibits and attachments hereto, constitute the entire agreement of the parties. The agreement supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to this Policy must be mutually agreed upon by both Delta Dental and Client. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Client for distribution to Enrollees do not constitute a part of this Policy.

Indemnity
Delta Dental agrees to indemnify, defend, and hold harmless Client, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of Delta Dental, its officers, agents, or employees, to perform any of the activities, duties or responsibilities specified herein. Client agrees to indemnify, defend, and hold harmless Delta Dental, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Client, its officers, agents, or employees to perform any of the duties or responsibilities specified herein.

Liability
Delta Dental arranges for the provision of vision care services and materials through agreements with Preferred Providers. Preferred Providers are independent contractors and are responsible for exercising independent judgment. Delta Dental does not directly furnish vision care services or supply materials. Under no circumstances shall Delta Dental or Client be liable to each other for the negligence, wrongful acts or omissions of any doctor, non-owned laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

Assignment
Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto, except as expressly authorized herein. Delta Dental may assign certain administrative functions to a third- party administrator without consent of the Client.

Severability
Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

Governing Law
This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in conformance with, applicable federal or State of Tennessee statutes or regulations is hereby amended to conform with the requirements of such statutes or regulation, now or hereafter existing.

Gender
All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

Equal Opportunity
Delta Dental is an Equal Opportunity employer.

Preservation of Confidentiality
Delta Dental shall hold in strict confidence all Confidential Matters. Delta Dental will use its best efforts to prevent any of its employees, Preferred Providers, or agents, from disclosing any Confidential Matter. Delta Dental may disclose Confidential Matters as allowed or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law.