DeltaVision Essential 150 Plan and DeltaVision Brilliance 200 Plan Endorsement

This endorsement makes administrative changes to Delta Dental of Washington's DeltaVision Policy that had been previously issued to you.

The changes reflected below are effective **January 1, 2024**:

1) All references to the vision claims mailing address of **P.O. Box 385018 Birmingham, AL 35238-5020** have been deleted and replaced with the following: **P.O. Box 495918 Cincinnati, OH 45249**.
2) All references to the vision appeals mailing address of **3333 Quality Drive, Rancho Cordova, CA 95670-7985** have been deleted and replaced with the following: **P.O. Box 2350 Rancho Cordova, CA 95741**.
3) All references to the vision complaints and grievances mailing address of **3333 Quality Drive, Rancho Cordova, CA 95670-7985** have been deleted and replaced with the following: **P.O. Box 997100 Sacramento, CA 95899-7100**.
4) Reference to the customer service phone number of **800-428-4833** has been deleted and replaced with the following: **800-877-7195**.
5) Language and a website link have been added to define Wyssta Services Inc. as Delta Dental of Washington's Health Care Benefit Manager.
6) **Section: Premium Grace Period**
    - The policy language in the Premium Grace Period section has been removed in its entirety and is being replaced with the following:
        - After your initial premium payment, you have a 30-day grace period, from the payment due date shown on your Declaration Page, to pay your premium. We will put a hold on paying your claims starting on the first day of the month after a missed premium payment. Payment for your claims will stay on hold until your premium payment is made. If you do not make a premium payment within the 30-day grace period, we will terminate this Policy for non-payment, and anyone covered under this Policy will lose coverage. Any claims held during the grace period will be denied and the cost will be your responsibility.
7) **Sections: Mid-Term Termination by You and Mid-Term Termination by Delta Dental of Washington**
    - The 24-month lockout period for terminating your policy prior to the completion of your contract term is being changed to a 12-month lockout period throughout.

8) **Section: Effective Date of Termination**
    - The Effective Date of Termination is being changed from the last day of the grace period to last day of the month for which premiums were paid.

If you have any questions regarding this information, please contact VSP® by phone at 800-877-7195.

Except as provided in this Endorsement, all other terms and conditions of the Vision Care Service Policy apply and remain unchanged.

DeltaVision®
In Partnership with VSP®

Welcome to your
DeltaVision Brilliance 200 Plan
from
Delta Dental of Washington

Vision benefits are important to you and to those around you. Thank you for recognizing this and purchasing your vision benefits from Delta Dental of Washington.

This policy is underwritten by Delta Dental of Washington and administered by VSP and Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc.

Throughout this document the term "You" refers to the person who bought this policy.

This document is your policy, which is a contract for vision benefits coverage. Please read it from start to finish. Also, please hold onto this document. It has answers to many questions about your vision benefits coverage.

The application you filled out is part of this policy. If any part of the application is wrong, please let us know right away. Wrong information may affect your coverage. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If you're not satisfied with this policy you can return it anytime within 10 days of the date we deliver it to you. We'll void the policy and refund your money, less any payment for claims you incurred. If we do not refund your money within 30 days after receiving the returned policy, we will pay you an additional 10% of the payment to be refunded.

This policy is only available to residents of Washington State. If you're not a Washington State resident, or an eligible dependent of a Washington State resident, this policy will not cover you. However, if you tell us what state you live in we may be able to refer you to a different DeltaVision policy.

This policy is available for you to review without purchase. If you are reviewing this policy prior to purchasing it, you will not receive any additional information from DDWA unless you decide to purchase this policy. If you purchase this policy, additional information will be sent to you.

Now, about your plan …

Questions Regarding Your Plan

Your plan is administered by VSP. If you have questions regarding your vision plan, you may reach VSP as follows:

VSP Customer Service:

800-877-7195

www.vsp.com

Vision Service Plan
Sacramento, CA 95899-7100

Vision Claims:

Vision Service Plan

P.O. Box 385018
Birmingham, AL 35238-5020

Vision Grievance and Appeals:

Vision Service Plan Insurance Company
Attention: Complaints and Grievances Unit
3333 Quality Drive
Rancho Cordova, CA 95670-7985

For the most current listing of providers that are part of the VSP Doctor Networks, visit the VSP online directory at www.VSP.com, or call VSP at 800-877-7195.

How to use your Plan

Please see the helpful tips below regarding how to use this Plan.

- Contact VSP to obtain a list of participating providers, and/or to view available benefits. You may visit VSP's website at www.VSP.com or call them at 800-877-7195.
- When you are ready to schedule your appointment, contact a VSP Doctor's office and let them know that you are a VSP member.
- Once you have scheduled an appointment, the provider will verify your benefits with VSP. VSP Doctors will bill VSP directly, but you will be responsible for payment of any Copayments, non-covered services or materials, or amounts that exceed plan

allowances, and annual maximum benefits.

When does my coverage start?

During the enrollment process you will be asked to select the month you would like your coverage to begin. You may enroll up to 2 months prior to the requested effective date. After your application is approved, your coverage starts the first day of the month and continues for 12 months, as shown on the declaration page. When you purchase this policy, you are committing to keeping it for at least 12 months.

Please note: Vision benefits are only offered in conjunction with a Delta Dental of Washington Dental Plan.

How do I renew my coverage?

The day after the end of the 12-month policy period is the "Renewal Date". Prior to that time we will send you information about your upcoming renewal. The amount of premium you pay may change at renewal, but we will tell you of your new premium at least 30 days before your Renewal Date. However, if we increase your rate 25% or more, or if we decrease any benefits under your policy, DDWA will send you written notice of the new rate or benefit changes at least 60 days before the Renewal Date. If we don't hear from you after we send this information, and you still qualify for coverage, your policy will automatically renew for an additional 12-month policy term with the new rates and/or benefits.

Can I cancel my policy?

You may only cancel your policy before the Renewal Date for the reasons listed in the "Mid-Term Termination by You" section. You may elect to not renew at the Renewal Date without any penalty or waiting period.

What if I have other vision coverage?

This Plan does not coordinate benefits. If you have other vision coverage, this Plan will pay as primary. We will not coordinate benefits with any other Plan you may have.

What about coverage for my family?

Your spouse or domestic partner and children can be covered under this policy as long as they're eligible. If they're no longer eligible as dependents, but are still Washington residents, they can purchase their own policy. Please see the "Who Is Eligible For Coverage?" section below for details.

Notices

Information sent to you will be sent to your last known physical address or email address. Please let us know right away if you move or change email addresses.

Any notice sent to DDWA must be sent by the Policyholder or authorized representative in writing (either electronically or by U.S. Postal Service). The notice is considered delivered when sent to us through your account at www.DeltaDentalCoversMe.com; or at the email address shown below; when given in person; when sent by fax; or when sent registered or certified United States mail, return receipt requested, proper postage prepaid, and properly addressed to:

Delta Dental
P.O. Box 103
Stevens Point, WI 54481-0103

Email: CustomerService@DeltaDentalCoversMe.com

You may also contact us by phone or fax for questions, to provide us with general information, or to provide us notice of an urgent care request or appeal.

Phone: 888-899-3734

Fax: 800-807-1970

Please see the "Appeals of Denied or Modified Claims" section for more detailed information on sending an appeal request.

Your Plan Details

Who Is Eligible For Coverage?

Only Washington State residents 18 years of age or older may purchase this policy. You may also include the following people under your policy:

1. Your spouse or domestic partner (registered or non-registered).
2. Dependent child(ren), through age 25, of you or of your spouse or domestic partner. Dependent Children include biological children, stepchildren, adopted children, and foster children.

   Enrolled Dependent Children who are, and continue to be, dependent beyond age 25 due to developmental disability or physical disability will not be terminated provided that proof of incapacity and dependency is furnished to DDWA within 31 days of the child's attainment of the limiting age and the child was an enrolled dependent upon attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first 2 years.

Please note: If your dependent has vision coverage under any other plan, this plan will be considered primary. We will not coordinate benefits.

Coverage for a Newborn, Adopted or Foster Child

A newborn is covered from the moment of birth, and an adopted child is covered from the date of assumption of a legal obligation for total or partial support of the child or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement. Vision coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children. Although newborn coverage will be from the moment of birth, any premium will not be required until the first of the following month. The enrollment must be received within 90 days of the birth or adoption if your premium increases. We recommend that you let us know of the addition as soon as possible so we can advise you of any potential premium increase and accurately pay any claims for services.

Adding or Removing Dependents

You may request to add any eligible person to this policy by submitting an application. If the application is accepted, the newly-covered person will be added to your policy at the beginning of the next month. You will be charged for the added dependent effective the date they are added. This process does not apply to newborn and newly placed or adopted children; please see the "Coverage for a Newborn/Adopted Child" section for more information. You may only drop a dependent at renewal, or for one of the reasons described in the "Mid-Term Termination by You" section. If you are dropping a dependent at renewal, please notify us in writing prior to renewal.

VSP Doctor Network

Providers who participate in the VSP Doctor Network (VSP Doctors), have agreed to provide services and supplies to patients covered by a VSP vision plan. They are called 'Participating' Providers, because they participate in our program of plans. For your Plan, the most current listing of Participating Providers can be found by going online to the VSP website at www.VSP.com. You may also call VSP at 800-877-7195.

Out-of-Network Doctor

Providers who do not participate in the VSP Doctor Network (VSP Doctors) are called Out-of-Network Doctor. This plan does not provide coverage for materials or services received by an Out-of-Network Doctor.

What is Covered and What You Pay

Maximum Benefit

Some Covered Vision Benefits have a maximum benefit, which may include a maximum dollar amount, number of visits, or established frequencies. For those, coverage will be provided up to the established maximum. See the "Your Vision Benefits" section for detailed information regarding covered vision benefits for this Plan.

Plan Allowance

The Plan Allowance is the maximum dollar amount that will be paid for a specific service or material. Your plan will pay up to the dollar amount listed in the Plan Allowance sections for each benefit. If the cost is less than your Plan Allowance, the plan will pay the actual invoiced amount. Costs that are more than the Plan Allowance are your responsibility. See the "Your Vision Benefits" section for detailed information regarding covered vision benefits for this Plan.

Your Vision Benefits

The following vision benefits are covered under this Plan. Benefits are subject to the Plan Allowance, Copayments, limitations and exclusions (see the "General Exclusions" section) contained in this benefit booklet. This plan is designed to cover visual needs and not cosmetic materials.

Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

Eye Examinations

Covered Vision Benefits

- Comprehensive examination of visual functions and prescription of corrective eyewear.

Limitations

- Comprehensive examinations are covered once every 12 months.

Plan Allowance

Description	VSP Doctor Network
Eye examination	Covered in full

VSP WellVision™ Exam

Your VSP Doctor will conduct a VSP WellVision Exam and will do the following during your exam:

- Review your case history.
- Evaluate your visual systems.
- Perform a neurological integrity assessment.
- Complete a refractive status evaluation.
- Assess your binocular function.
- Diagnose and provide a treatment plan.

Lenses

Covered Vision Benefits

- Lenses (single vision, lined bifocal, lined trifocal, or lenticular).
- Standard progressive lenses.
- Polycarbonate lenses for children.

Limitations

- Prescription eye glass (lenses and frames) coverage is provided in place of coverage for contact lenses.
- One set of lenses are covered every 12 months.
- Polycarbonate lenses are covered in full for dependent children up to age 26.

Plan Allowance

Description	VSP Doctor Network
Single vision lenses	Covered in full
Lined bifocal lenses	Covered in full
Lined trifocal lenses	Covered in full
Lenticular lenses	Covered in full
Lens enhancement: Standard progressive lenses	Covered in full
Lens enhancement: Polycarbonate lenses (for children)	Covered in full

Lens Enhancements

Your plan covers the following lens enhancements:

- Standard progressive lenses.
- Polycarbonate lenses for children.

Your plan allows you to purchase additional lens enhancements that are not covered by your plan, the cost of those enhancements is your responsibility. Purchase of non-covered lens enhancements does not impact your Plan Allowance for your lenses or frames.

Frames

Covered Vision Benefits

- Frames, including assistance with frame selection and adjustment.

Limitations

- Prescription eye glass (lenses and frames) coverage is provided in place of coverage for contact lenses.
- Covered once every 12 months.

Plan Allowance

Description	VSP Doctor Network	Costco Optical or Walmart Optical Participating Providers
Frames	$200*	$110**

*You will receive an additional 20% savings on any amounts over the Plan Allowance.

**Costco and Walmart in-store Optical Centers are part of the VSP Doctor Network. Purchases online from Costco.com and Walmart.com are not reimbursable.

Contact Lenses

Covered Vision Benefits

- Contact lens fitting and evaluation.
- Elective contact lenses.
- Necessary contact lenses.

Limitations

- Contact lens coverage is provided in place of coverage for prescription glasses

(lenses and frames).

- Elective contact lens fitting, and evaluation services are covered in full once every 12 months.
- Necessary contact lenses are covered in full, once every 12 months.
- Necessary contact lenses are a Plan Benefit when covered person's VSP Doctor determines that contact lenses result in better visual correction than eye glasses, due to a visual/medical condition.

Plan Allowance

Description	VSP Doctor Network
Elective contact lenses	$200
Necessary contact lenses	Covered in full

What We Don't Cover

The benefits covered under this plan are subject to limitations listed in the benefits sections above which affect the type or frequency of procedures which will be covered. Additionally, this Plan does not cover every aspect of vision care. There are exclusions to the type of services and materials that are covered, which are detailed here. Please read all limitations and exclusions carefully.

These items are not covered benefits under this Plan.

- The following Patient Enhancements are not covered under this Plan, but may be added to covered materials at your expense. This includes:
  - Optional cosmetic processes.
  - Anti-reflective coating.
  - Color coating.
  - Mirror coating.
  - Scratch coating.
  - Blended lenses.
  - Cosmetic lenses.
  - Laminated lenses.
  - Polycarbonate lenses, except where otherwise noted.
  - Oversize lenses.
  - Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
  - UV (ultraviolet) protected lenses.
- Services and/or materials not specifically included in this policy as covered plan benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- 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.
- 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 your plan is required by law to pay.

Claim Review

Filing Claims

When you receive care from your VSP Doctor, the provider will submit the claim directly to VSP for payment.

Timely Submission of Claim Forms and Reimbursement

Your Plan is not obligated to pay for services or supplies for which claim forms are submitted for payment more than 12 months after the date of such service. Claim forms must be received within 12 months of the date of service.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission for payment modification or denial of the claim. In accordance with regulatory requirements, all clean claims are processed within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

This 30-day period may be extended by no more than 15 days if the claim in the following situations:

- When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when we expect to act on the claim.
- When we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow you at least 45 days to provide us with the additional information that we are requesting from you. If we do not receive the requested information within that timeframe, your claim may be denied in whole or in part, or modified.

If a claim is denied, in whole or in part, or is modified, we will send you an Explanation of Benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied or Modified Claims

How to contact us

We will accept notice of an urgent care, grievance, or appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us at the telephone number below, submitting the form available on www.vsp.com, or in writing us at the following address: Vision Service Plan Insurance Company, Attention: Complaint and Appeals Unit, P.O. Box 997100, Sacramento, CA 95899-7100. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 800-428-4833.

Authorized Representative

You may authorize another person to represent you or your covered dependent and to receive communications from VSP regarding specific appeal. The authorization must be in writing and signed by you or covered dependent if they are age 18 or older. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Initial Appeal

The request for review must be made within one hundred eighty (180) calendar days following denial or modification of a claim and should contain sufficient information to identify the claim and the covered person affected by the denial. The covered person may review, during normal working hours, any documents held by VSP pertinent to the denial. The covered person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the covered person within thirty (30) calendar days after receipt of a request for an appeal from the covered person.

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. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, covered person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to covered person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Time of Action

No action in law or in equity shall be brought to recover on the policy prior to the covered person exhausting his/her grievance rights under the policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the policy.

Complaints and Grievances

Covered persons have the right to expect quality care from VSP Doctors. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the covered person of the expected resolution date. Upon final resolution VSP will notify the covered person of the outcome in writing.

How to Report Suspicion of Fraud

If you suspect a provider, an insurance producer or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907.

You may also want to alert any of the appropriate law enforcement authorities including:

The National Insurance Crime Bureau (NICB). You can reach the NICB at 800-835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).

The Office of the Insurance Commissioner (OIC). You can reach the OIC at 360-725-7263 or go to www.insurance.wa.gov for more information.

Premiums

Current Policy and Renewal

This policy is effective for 12 months, starting with the policy's effective date as shown on the declaration page. After that, you can renew this policy, if you and any other people covered under this policy remain eligible, and if premiums are paid according to the procedure described in this document.

Rates and Financial Obligations

The current premium rates are listed on the Declaration Page.

DDWA may change the rates and/or benefits under this policy on this policy's Renewal Date. DDWA will send you written notice of a rate change at least 30 days before your Renewal Date. However, if we will be increasing your rate 25% or more, or decreasing any benefits under your policy, DDWA will send you written notice of the new rate or benefit change at least 60 days before the Renewal Date.

Legislative Surcharge Clause — If any governmental unit imposes any new tax or assessment or increases the rate of any current tax or assessment that is measured directly by the payments made to DDWA by you, or payments made by DDWA for claims, then DDWA is authorized to increase the monthly premium by the amount of such new tax, assessment or increase.

Premium Due Date

The first premium for this policy is due the day we accept your application for coverage. You can pay premiums monthly, semiannually or annually. The time period you choose is called a "premium period." Premiums are due the on the due date shown on your Policy Declaration Page.

Premium Grace Period

You have a 30-day grace period to pay your premium. You are still covered during the grace period. If you don't pay your premium within the grace period, you will lose coverage on the last day of the grace period and we will terminate this contract.

Canceling this Policy

Mid-Term Termination by You

When you purchase or renew this policy, you are committing to keeping it for a 12-month period. To cancel your policy before the end of the 12-month commitment, you must send a written request prior to the requested date of termination. We will terminate your policy at the end of the month in which we receive your written request.

You may terminate your policy before the end of your 12-month commitment for one of the following reasons without any adverse impact.

1. You become covered under a group vision plan offered at work. If anyone else covered under this policy becomes covered under a group plan, they may be terminated without terminating the entire policy. If you or your dependent becomes covered under another individual vision plan, you will still be obligated to continue this plan.
2. You die. In that instance, the policy would terminate and anyone else covered under your policy who meets the eligibility standards may choose to continue with a separate

policy. If a covered person other than you dies, you can terminate their coverage without terminating the entire policy.

3. You enter into full-time United States military service. In that instance, the policy would terminate and anyone else covered under your policy who meets the eligibility standards may choose to continue the policy. If a covered person other than you enters military service, you may terminate their coverage without terminating the entire policy.

If any of the above events occur, and you want to terminate your policy or coverage for a dependent under your policy, you must tell us in writing within 30 days of the event.

If you terminate your vision policy prior to the end of your 12-month commitment for any reason not listed above, you will not be allowed to purchase another Delta Dental of Washington Individual vision plan for 24 months.

If you terminate your vision coverage prior to the end of your 12-month commitment, we will refund any premium paid for coverage after your termination date less any claims incurred after that termination date.

Mid-Term Termination by Delta Dental of Washington

We can terminate your policy before its annual renewal for the following reasons:

1. You don't pay the premium payment when it's due;
2. You or a covered dependent commits fraud related to this policy or any other policy you have with DDWA; or
3. Someone other than you or a covered dependent uses your vision coverage.

If we terminate your vision coverage prior to the end of your 12-month commitment, we will refund your unused premium payment, less any claims incurred. If we terminate your vision policy for any of these reasons, we may not allow you to purchase another Individual vision plan from DDWA for a 24-month period.

How to End Your Policy at Renewal

This policy will automatically renew. If you don't want to renew this policy, or coverage for a dependent under this policy, send us written notice (either electronically or through the regular mail) before the policy's Renewal Date. Requested changes to this policy will go into effect on the Renewal Date. If non-renewal is requested, this policy will end on the last day before the Renewal Date.

We may elect to not renew this policy if the premiums are not paid on time, or if the Plan that you are enrolled in terminates. If we elect not to renew this policy we will notify you in writing (either electronically or through the regular 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 vision benefits coverage for you and/or other people covered under this policy stops on the date this policy is terminated. That date is the earliest of the following:

1. The day following the last day of any grace period, if the premium hasn't been paid; or
2. The last day of the month we receive a termination request from you, or the last day of any later month stated in your request; or
3. The last day before the Renewal Date if this policy is not renewed, or
4. The last day of the month after the date of your death; or
5. The last day of the month after the date of death of a person covered under this policy other than you, but only for that person; or
6. The last day of your current policy period if you (the subscriber) move out of Washington. Dependents remaining in Washington that wish to continue coverage may enroll in a new policy.

If anyone covered under this policy commits fraud related to this policy or any other policy you have with DDWA, 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 for you. If the claims we paid are more than the premium you paid, you will have to pay us the difference.

Conversion Option

If your vision coverage stops because your eligibility ends as a result of termination of marriage or domestic partnership, or the policyholder's death, you may obtain an individual policy without a physical examination, statement of health, or other proof of insurability. You may get additional information by contacting VSP at 800-877-7195.

General Terms

Delta Dental of Washington's Responsibility

DDWA is responsible for providing the administrative services detailed in this policy, and for paying claims for services properly incurred under this policy.

Compliance with Laws and Regulations

This Contract shall be in compliance with all pertinent federal and state laws and regulations, including, but not limited to, the applicable health care privacy and disclosure provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If this Contract or any part hereof, is found not to be in compliance with any pertinent federal or state law or regulation, then DDWA shall amend the Contract for the sole purpose of correcting the noncompliance.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your visual health information in compliance with the Health Insurance Portability and Accountability Act. You

can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling DDWA at 800-554-1907.

Governing Law

This contract is issued and delivered in the state of Washington and obeys its laws and regulations. On the effective date of this contract, any term, condition, or provision conflicting with Washington State laws and regulations applying to this contract will automatically conform to the minimum requirements of such laws and regulations.

Non-waiver and Severability

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

Entire Contract Changes

The entire contract between you and us consists of this policy, which includes the benefits, limitations and co-payments, the declaration page, any and all endorsements or riders, and the application.

No oral statements by anyone can change or affect any aspect of this contract.

Any Questions?

If you have problems with Delta Dental of Washington or any producer contact them to resolve your problem. You can contact DDWA at the address and telephone number provided in the "Notices" section.

The Office of the Insurance Commissioner is a state agency that regulates Washington State insurers. To file a complaint with the Office of the Insurance Commissioner write to:

Washington State Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA 98504-0256
Phone: 800-562-6900 or 360- 725-7080
Fax: 360- 586-2018

Nondiscrimination and Language Assistance Services
Delta Dental of Washington complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Washington:

We will provide free aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We will provide free language and services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: (800)554-1907. If you need translation or interpreter assistance at your VSP Doctor's office, please contact their staff. The cost for translation and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: (800)554-1907, TTY: 800-833-6384, Fx: (206) 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington DC 20201, 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Taglines
Amharic
እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።
Arabic
إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.

Taglines
Cambodian (Mon-Khmer) ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 800-554-1907។
Chinese 如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。
Cushite (Oromo) Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.
French Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.
German Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.
Japanese ご本人様、またはお客様の身寄りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907 までお電話ください。
Korean 귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington 에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907 로 전화하십시오.
Laotian ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.
Persian (Farsi) اگر شما، یا شخصی که به وی کمک می کنید، سؤالی درباره‌ی Delta Dental of Washington دارد، این حق را دارید که اطلاعات مورد نیازتان جهت صحبت با یک مترجم شفاهی، با شماره را به زبان خود و بدون هیچ هزینه‌ای دریافت کنید. 800-554-1907 تماس بگیرید.
Punjabi ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.
Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.

Taglines
Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.
Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.
Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde modon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.
Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.
Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.
Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.