KCSD
Kenton County School District | *It's about ALL kids.*

Issue Paper

DATE:
October 27, 2023

AGENDA ITEM (ACTION ITEM):
Consider/Approve: Section 125 Plan providers and Hartford Tax Services Agreement

APPLICABLE BOARD POLICY:
01.11 General Powers & Duties of the Board

HISTORY/BACKGROUND:
On August 7, 2023 the Board awarded the position of Section 125 Plan Administration to the Houchens Company. Houchen's strategy to provide employees with premium savings and/or increased coverage is accomplished by researching and selecting the best available service providers. Two provider changes have been recommended for the 2024 plan offerings, short-term disability will be provided by The Hartford Co. instead of Colonial Ins. and vision will be provided by Delta Vision instead of Avesis. These changes will result in premium savings and increased coverage for a majority of current enrollees. In addition, The Hartford Co. will provide tax services for any taxable transactions related to the short & long term disability policies per their Tax Services Agreement attached.

FISCAL/BUDGETARY IMPACT:
None

RECOMMENDATION:
Approval of the Hartford as the provider for the short-term disability policy, Hartford Tax Services Agreement, and Delta Vision as the provider for the vision policy for the KCSD Section 125 Plan.

CONTACT PERSON:
Susan Bentle, Exec Director Finance

	Susan Bentle	
Principal/Administrator	*District Administrator*	*Superintendent*

Tax Services Agreement

Short Term Disability (STD)

POLICYHOLDER/EMPLOYER NAME: Kenton County Board of Education

POLICY NUMBER: 879069

EFFECTIVE DATE OF REQUEST (current or future date only): 1/1/2024

A. Policyholder/Employer has provided the following information to The Hartford* regarding who bears the cost of premiums, whether the costs are incurred pre-tax or post-tax, and the taxability of benefits.

The following tax treatment applies to the following group of employees: ALL

- Employees pay the premium costs with post-tax income. Benefits are 0% taxable.

B. STANDARD TAX SERVICES

- The Hartford will withhold and deposit applicable and properly elected additional United States federal income taxes (FIT) and state income tax (SIT) as well as applicable Employee FICA taxes from disability benefits/sick pay. The Hartford will make timely filings with the appropriate United States federal and state agencies.
- The Hartford will deposit the taxes using The Hartford's tax identification number and will timely notify Policyholder/Employer of these payments. This notification is provided to you on the Claim Payment Report which is sent to you based upon the frequency you elected.
- The Hartford assumes no responsibility for the Policyholder/Employer's share of FICA (unless FICA Match and W-2 Services are elected).
- The Hartford assumes no responsibility for any other payroll or employment related tax, fee, premium or the like including Federal Unemployment Insurance (FUTA) and State Unemployment Insurance (SUTA), State Disability Insurance, State or Local Occupational Taxes, other jurisdictional taxes such as municipal, city or county taxes, or any Workers' Compensation Tax which may be applicable to the disability benefits The Hartford is paying. The Hartford will provide standard periodic reporting to assist the employer in making deposits of FUTA and SUTA funds. For income sourced to states that require an employee contribution of SUTA, Hartford will deduct the Employee's share of the unemployment obligation and comply with the appropriate state deposit rules. The Hartford will remit the withheld employee SUTA funds to the employer for deposit with the appropriate state governmental agency and assumes no responsibility for the deposit and filing of the Employee share of the unemployment obligation with the appropriate state government agency.
- The Hartford will prepare and deliver to Policyholder/Employer the annual summary reports of benefits paid.

C. OPTIONAL SELECTED TAX SERVICES

- If you have a payroll vendor, to avoid duplication of services, it is your responsibility to provide that vendor with notice of the applicable services The Hartford will provide as identified and selected below.
- Unless you specifically request different Optional Tax Services for different sub-groups of employees, we will apply the Optional Selected Tax Services as identified in Sections C.1 and C.2 below to all employees.

1. W-2 SERVICES

The following tax treatment applies to the following group of employees: ALL

- Policyholder/Employer declines The Hartford service to prepare Forms W-2 for payees or file federal and state information returns reporting disability benefits/sick pay. The Hartford will provide Policyholder/Employer by January 15th of each year the information required by federal law to enable Policyholder/Employer to prepare Forms W-2 for its active and terminated employees.
- If the benefit plan covers disability income sourced to a state that requires The Hartford as a Third Party Payer of sick pay benefits to retain the reporting obligation for the benefit plan, The Hartford will issue Forms W-2 for those particular states. (For example: Wisconsin)

*The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

2. **FICA MATCH SERVICE (W-2 Services must be authorized above if Policyholder/Employer authorizes FICA Match Services.)**

The following tax treatment applies to the following group of employees: ALL

The following tax treatment applies to the following plan(s): Fully Insured STD

- Policyholder/Employer declines The Hartford's FICA Match Service and will report and deposit its share of any FICA tax on benefits paid, if applicable.

D. GENERAL PROVISIONS

1. Changing Selected Tax Services

- Policyholder/Employer agrees that any service change regarding Forms W-2 must be requested in writing on or before November 15th of the current tax year. Any change in W-2 Services after November 15th may result in Employees receiving Forms W-2 after January 31st or possible duplicate forms issued from both The Hartford and Policyholder/Employer.
- Policyholder/Employer agrees that any service change regarding Employer FICA Match service will be effective on January 1st following the date on which a new Tax Service Agreement has been signed and submitted to The Hartford.

2. Accurate and Timely Information

- Policyholder/Employer agrees to provide The Hartford with accurate and timely information to enable The Hartford to provide Standard Tax Services and any Selected Tax Services, including all information necessary to determine the taxable portion of the benefits. Any and all changes regarding Section A above must be timely communicated to The Hartford and a new Tax Services Agreement will be executed. Submission by Policyholder/Employer of incorrect information related to the taxable portion of benefits which later requires The Hartford to retroactively correct claimant net benefits may result in fees payable to The Hartford to cover reasonable processing.

3. Hold Harmless

- Policyholder/Employer agrees to indemnify and hold The Hartford harmless from any and all liability, including but not limited to fines or penalties that may result from erroneous, incomplete, or untimely information provided by Policyholder/Employer to The Hartford in connection with the Standard Tax Services and any Selected Tax Services and The Hartford's performance of its duties under this Agreement.

4. Pricing for Selected Services

- Policyholder/Employer agrees that the Fully Insured FICA Match Service will require underwriter review. If selection of this Service results in a change in premium, The Hartford will promptly notify Policyholder.
- Policyholder/Employer agrees that the ASO W-2 and FICA Match Services will require underwriter review. If selection of this Service results in a change in fees, The Hartford will promptly notify Employer.

Kenton County Board of Education

Legal Name of Entity

_____ _____

Signature **Date of Signature**

_____

Name and Title of Authorized Signer

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com.

DELTA VISION

Administered by VSP
Vision Care for Life

KENTON COUNTY BOARD OF EDUCATION
VISION CARE POLICY
DECLARATIONS

Client (Group) Name:	**KENTON COUNTY BOARD OF EDUCATION**
Policy Number:	**70531V**
State of Delivery:	**KENTUCKY**
Effective Date:	**01/01/2024**
Policy Period:	**01/01/2024-12/31/2025**

This Contract is between Client (the "Contractor"), and Delta Dental of Kentucky, Inc., a Kentucky not-for-profit corporation ("Delta Dental"). Delta Dental agrees to provide Plan Benefits to Covered Persons as described in this Contract (the "Policy") including any attachments, and subject to the exceptions, limitations and exclusions contained herein. This Policy is delivered in and governed by the laws of the Commonwealth of Kentucky. Delta Dental's liability is limited to the Plan Benefits stated in this Contract. This Declarations Section supersedes any other provision contained in subsequent sections of this Contract.
The policy itself sets forth, in detail, the rights and obligations of both parties. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.

DELTA DENTAL OF KENTUCKY, INC.

President & CEO

Date:

CONTRACTOR- KENTON CO BOE

(Authorized Signature)

Title:

Date:

Witnessed by:

(Signature)

Date:

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I.

TERM, RENEWAL AND TERMINATION

1.01. Term. This Policy shall commence on the Effective Date noted on the front page of this Policy, and shall remain in effect for the Policy Period, also noted on the front page of this Policy.

1.02. Renewal.

(a) Delta Dental shall issue written renewal notice to Client at least sixty (60) days before the end of the Policy Period. If Client fails to accept the renewal terms and/or rates in writing prior to the end of the Policy Period, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Period.

(b) If Client wishes to renew the Policy but acceptance of the renewal cannot be formalized before the end of the Policy Period, or if the parties continue to negotiate renewal terms after the Policy Period, Client may submit a written request to have the Policy renew on a temporary month- to- month basis under the expired contract terms, not to exceed six months, until Client's acceptance of the renewal is formalized in writing and a new Policy is issued. Once renewal is accepted, Delta Dental reserves the right to bill Client retroactively at the renewal premium for the temporary month-to-month renewal period. During the temporary month to month period, either party may terminate the Policy by providing thirty (30) days advance written notice to other party.

1.03. Termination.

(a) This Policy may be terminated by either the Client or Delta Dental upon expiration of a

Policy Period as set forth in paragraph 1.02.

(b) This Policy may also be terminated by Delta Dental immediately upon written notice, if Client fails to:

(i) Pay premiums by the dates defined in paragraph 3.04.

(ii) Report a material change in accordance with paragraph 3.03.

(c) If Client terminates this Policy as of any date other than the end of the Policy Period, such termination will be treated by Delta Dental as a breach by Client.

(d) If this Policy is terminated under paragraph 1.03(b) or (c), coverage is terminated and Delta Dental is released from all obligations of this Policy, effective as of the termination date (except for preexisting obligations specifically set forth in Section 1.03 (e), below). Client will remain liable to Delta Dental for the lesser amount of any deficit incurred by Delta Dental or the payments which Client would have paid for the remaining term of this Policy, not to exceed one year. A deficit incurred by Delta Dental will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by Delta Dental from Client over the current term. Net premiums shall mean premiums paid by Client minus any applicable retention amounts and/or broker commissions. Client shall also be responsible for any legal and/or collection fees incurred by Delta Dental to collect amounts due under this Policy.

(e) If this Policy is terminated for any cause as stated in this section 1.03, Delta Dental is not required to pay for services provided after such termination date, except for any outstanding, unexpired benefit that is authorized before termination, or any other claim obligations that arose prior to termination.

II.

OBLIGATIONS OF Delta Dental

2.01. Coverage of Covered Person. Delta Dental will enroll for coverage, as directed by Client, each eligible Enrollee and his/her Eligible Dependents (if dependent coverage is provided), all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Delta Dental, , may require Client to complete, sign and forward to Delta Dental a Client Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums.

Following the enrollment of the Covered Persons, Delta Dental will provide Client with an Evidence of Coverage for distribution to Covered Persons by Client. Such Evidence of Coverage and Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

2.02. Administration of Plan Benefits. Routine vision benefits are administered by Vision Service Plan Insurance Company ("VSP") and VSP Preferred Providers (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from, an Open Access Provider). We shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A(s)) and when purchased by Client, the Additional Benefit Rider (Schedule C(s)) attached hereto, subject to any limitations, exclusions, or Copayments therein stated. VSP Preferred Providers have agreed to accept payments for services with no additional billing to the Covered Person other than Copayments, applicable tax, co-insurance and any amounts for non-covered services and/or materials.

A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from a VSP Preferred Provider. When a Covered Person seeks Plan Benefits from a VSP Preferred Provider, the Covered Person must schedule an appointment and identify himself/herself as a Delta Dental Covered Person so the VSP Preferred Provider can obtain a Benefit Authorization. . A Benefit Authorization will be issued to the VSP Preferred Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires Benefit Authorizations are issued in accordance with the latest eligibility information furnished by Client and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued shall constitute a certification to the VSP Preferred

Provider that payment will be made to VSP Preferred Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

VSP, as the administrator, shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP receives a completed claim. VSP may not request a refund or offset against a claim paid to a vision care provider more than twelve (12) months after it has paid a claim except in cases of fraud or misrepresentation by such provider.

2.03. Open Access Provider Services. When Covered Persons elect to utilize the services of an Open Access Provider, benefit payments for services from such Open Access Provider will be determined according to the Plan's Open Access Provider benefit fee schedule if Open Access Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Open Access Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of Delta Dental's Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Open Access Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed in accordance with the Open Access Provider reimbursement schedule shown on the attached Schedule of Benefits (Exhibit A (s)) and Additional Benefit Rider (Schedule C(s)) (if purchased by Client), less any applicable Copayments.

2.04. Information to Covered Persons. Upon request, Delta Dental shall make available to Covered Persons necessary information describing Plan Benefits and instructions for use. A copy of this Policy shall be provided to Client and will be made available at the offices of Delta Dental for any Covered Persons. Covered Persons may obtain information on VSP's Preferred Providers through VSP's website at www.vsp.com, VSP's Customer Care toll-free number (1-800-877-7195), or by written request. If Client supplies email addresses of Covered Persons to Delta Dental or VSP, Delta Dental and VSP may use the email addresses to communicate information to Covered Persons about their vision benefits.

2.05. Preservation of Confidentiality. Delta Dental shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, VSP Preferred Providers,

or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is permitted or required under 45 CFR Part 160, 162 and 164 ("HIPAA Privacy Rule") and in accordance with applicable law.

2.06. Urgent Vision Care. When vision care is necessary for Urgent Conditions, Covered Persons may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider, if Open Access benefits are available. Services for conditions of a medical nature are covered by Delta Dental only under supplemental eyecare plans. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider (Schedule C). If Client has not purchased one of these plans, Covered Persons are not covered by Delta Dental for such services and should contact a physician under Covered Persons' medical insurance plan for care.

For situations of a non-medical nature, such as lost, broken or stolen glasses, Covered Person should call VSP's Customer Care toll-free number (1-800-877-7195) for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

2.07. Coordination of Benefits. Unless otherwise agreed to by Client and Delta Dental, the following rules governing coordination of benefits shall apply. When Delta Dental is the primary insurer, it will pay benefits according to the terms of this Policy, subject to any applicable state or federal codes, statutes or regulations. 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.

III.

OBLIGATIONS OF CLIENT

3.01. Identification of Eligible Enrollees. An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified by the Client, and in accordance with applicable state and federal law. Client shall provide Delta Dental with required eligibility information, in a mutually agreed upon timeframe, format and medium, to identify all Enrollees who are eligible for coverage under this Policy.

3.02. Retroactive Eligibility Terminations. Retroactive eligibility changes are limited to the month in which notification is received by Delta Dental, plus two prior months. Delta Dental may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

3.03. Change of Client Composition. Client's percentage of Enrollees covered under the Policy as well as Client's contribution and eligibility requirements are factors used to determine rates and are considered material to Delta Dental's obligations under this Policy. During the term of this Policy and in accordance with section 1.03, Client must provide Delta Dental with written notification of any changes that will significantly impact utilization of the benefits and such changes must be agreed upon by Delta Dental. Nothing in this section shall limit Client's ability to add Enrollees or Eligible Dependents under the terms of this Policy.

3.04. Payment of Premiums. Upon receipt of Delta Dental's billing statement, Client shall remit to Delta Dental the premiums as set forth in Exhibit B. The premiums set forth in Exhibit B shall remain in effect for the term of this Policy unless the Client requests a change in the Schedule of Benefits and/or Additional Benefits Rider (if purchased by Client), or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by Delta Dental. Client premium payments are due upon receipt of Delta Dental's billing statement and shall become delinquent after thirty-one (31) days. If the premium payment remains unpaid the coverage may be cancelled and the Client will be responsible for payment for all Plan Benefits provided to Covered Persons. Client shall also be responsible for any legal and/or collection fees incurred by Delta Dental to collect amounts due under this Policy.

3.05. Distribution of Required Materials. Client shall provide to Enrollees any materials required by any regulatory authority, within the timeframe required under applicable law.

3.06. Communication Materials. Communication materials created by Client which relate to this Vision Care Policy may be submitted to Delta Dental and VSP for review and approval. Our review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Client's materials meet any applicable legal or regulatory requirements including, but not limited to, ERISA requirements. In the event of any dispute between the communication materials and this Policy, the provisions of this Policy shall prevail.

IV.

OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

4.01. General. This Policy provides coverage for Client's Enrollees. If Client offers dependent coverage, this Policy will also cover Enrollees' Eligible Dependents. This Policy may be amended or terminated by agreement between Delta Dental and Client without the consent or concurrence of Covered Persons. This Policy with any and all Exhibits and/or attachments constitutes the entire obligation of Delta Dental to Covered Persons.

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

4.03. Obtaining Services from VSP Preferred Providers. To utilize Plan Benefits, Covered Persons must select a VSP Preferred Provider, schedule an appointment and inform the doctor's office that they are Covered Persons of Delta Dental. The VSP Preferred Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from a VSP Preferred Provider without a Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Open Access Provider.

4.04. Open Access Provider Benefits. If required by state law, or if purchased by Client, this Policy provides Plan Benefits for services and materials received from Open Access Providers. Covered Persons or Open Access Providers may submit requests for reimbursement to VSP. VSP will pay available Plan Benefits to Covered Persons, or directly to Open Access Providers when claims include a valid Assignment of Benefits. VSP may deny any claims received after three hundred sixty-five (365) calendar days from the date services are rendered and/or materials provided.

4.05. Complaints and Grievances. VSP administers claims for Delta Dental. Complaints and grievances may be submitted by Covered Persons to VSP in writing, by telephone, online or through Covered Persons' VSP preferred Providers, as explained in the Evidence of Coverage for this Policy. VSP

will resolve all complaints and grievances within thirty (30) calendar days following receipt unless special circumstances require an extension of time. Where such extension is required, VSP will resolve all complaints and grievances as soon as possible, but not later than one hundred twenty (120) calendar days after receipt. If VSP determines that a complaint or grievance cannot be resolved within thirty (30) calendar days, it will notify Covered Person of the expected resolution date. VSP will notify Covered Person in writing of the final resolution of all complaints and grievances.

4.06. 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 VSP 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.

a) 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 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 communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

b) 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 VSP within sixty (60) calendar days after receipt of VSP's response to the initial appeal. VSP 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. VSP's communication to the Covered Person shall include the specific reasons for the determination.

c) 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.

4.07. 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.

4.08. 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, which is a crime. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

V.

CONTINUATION OF COVERAGE

5.01. 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.

5.02. 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.

VI.

DISPUTE RESOLUTION

6.01. 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 Delivery of this Policy shall be the applicable law.

VII.

NOTICES

7.01. 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 unless otherwise directed by Client. Notices to Delta Dental shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any 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.

VIII.
STANDARD PROVISIONS

8.01. Entire Agreement. This Policy, the Client Application, the Evidence of Coverage, and all Exhibits and attachments hereto, constitute the entire agreement of the parties and supersede 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.

8.02. 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.

8.03. Liability. Delta Dental arranges for the provision of vision care services and materials through agreements with VSP Preferred Providers. VSP Preferred Providers are independent contractors and are responsible for exercising independent judgment. Delta Dental does not itself 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-Delta Dental owned laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

8.04. 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.

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

8.06. 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 statutes or regulations is hereby amended to conform to the requirements of such statutes or regulation, now or hereafter existing.

8.07. 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.

8.08. Equal Opportunity. Delta Dental is an Equal Opportunity and Affirmative Action employer.

IX.

DEFINITIONS

The key terms in this Policy are defined:

9.01. 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.

9.02. ADMINISTRATIVE SERVICES PROGRAM. A self-insured vision care plan whereby Client pays Delta Dental for the Plan Benefits in addition to a monthly administrative fee

9.03 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 or our vision administrator VSP to pay available Plan Benefits to a named Open Access Provider.

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

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

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

9.07. COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985.

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

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

9.10. 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.

9.11. 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.

9.12. 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.

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

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

9.15. EVIDENCE OF COVERAGE ("EOC"). A summary of the provisions of this Policy, prepared by Delta Dental and provided to Client for distribution to Enrollees by Client.

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

9.17. 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.

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

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

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

9.21. 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.

9.22. 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.

9.23. SCHEDULE OF PREMIUMS. The document, attached as Exhibit B 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.

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

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

9.26. 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.

9.27. 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 Delta Dental and receive Plan Benefits in accordance with the terms of such Policy. The Policy includes any and all Exhibits and/or attachments thereto.

9.28. VSP. Vision Service Plan is operating as the routine vision benefits administrator for Delta Dental of Kentucky Plans.

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

EXHIBIT A

SCHEDULE OF BENEFITS
DeltaVision using VSP's Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of DELTA DENTAL OF KENTUCKY, INC. ("Delta Dental") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS THRU VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of [$0 - 30.00] for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional [$0.00 - $50.00] Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every – [12 or 24] months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every – [12 or 24] months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to age 26.
Standard Progressives lenses covered in full.

FRAMES - Covered up to the Plan allowance* once every – [12-24] months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

Elective

Elective Contact Lenses (materials only) are covered up to $0.00 - $500.00 once every – [12 or 24] months**

The Elective Contact Lens fitting and evaluation services are covered in full once every – [12 or 24] months**, after a maximum $60.00 Copayment.

Necessary
Necessary Contact Lenses are covered in full* once every – [12 or 24] months**

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.
*Less any applicable Copayment.
**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

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. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

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 Suncare enhancement, if purchased by Client.
- 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.

REIMBURSEMENT SCHEDULE FOR OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of [$0 .00-$30.00] for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional [$.00-$50.00] Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every –[12 or 24] months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $30 .00* once every – [12 or 24] months**

Bifocal Up to $50 .00* once every – [12 or 24] months**

Trifocal Up to $ 65.00* once every – [12 or 24] months**

Lenticular Up to $100.00* once every – [12 or 24] months**

FRAMES: Covered up to $ 70.00* once every – [12-24] months**

CONTACT LENSES

Elective

Elective Contact Lenses are covered up to $105.00 once every – [12 or 24] months**

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 $210.00 * once every – [12 or 24] months**

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 available herein.

*Less any applicable Copayment.
**beginning with the first date of service.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- We are unable to require Open Access Providers to adhere to VSP's quality standards.

Exhibit B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
DeltaVision using VSP's Choice Plan
V150+

Delta Dental shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$	8.67	per month for each eligible Enrollee without dependents
$	17.33	per month for each eligible Enrollee with an eligible spouse
$	18.01	per month for each eligible Enrollee with eligible child(ren)
$	28.79	per month for each eligible Enrollee with eligible spouse and child(ren)

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

Exhibit C

ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. 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 Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) 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 PEC Plan may include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

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

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

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's 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 Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES 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. Covered Person contacts VSP Network Doctor and makes an appointment.

2. Covered Person pays 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 Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Preferred Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.**

PLAN BENEFITS THRU VSP 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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons 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 VSP is required by law to pay.

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.

PLAN BENEFITS THRU OPEN ACCESS PROVIDERS

An Eyecare Professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered up to $100.00 less a Copayment amount of $20.00.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

Eye and Ocular Adnexa Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.