DeltaVision®

Network Administrator: EyeMed℠,
underwritten by Health Ventures Network

DeltaVision®150 Materials Only

SUMMARY PLAN DESCRIPTION

This is a Summary of your Client Vision Program
(**PROGRAM**) prepared for Covered Persons with:

DeltaVision®150 Materials Only

This Program has been established and is maintained and administered in accordance with the provisions of your Client Vision Plan Contract by DeltaVision® Network Administrator EyeMed℠ underwritten by Health Ventures Network (hereinafter DeltaVision®) (**PLAN**).

This booklet is subject to the provisions of the Client Group Vision Plan Contract. If there is an inconsistency between this booklet and the Client Group Vision Plan Contract, the Client Group Vision Plan Contract controls.

RIGHT TO INSPECT: As a participant in the Program, you are entitled to examine without charge at the Client Administrator's office and at other specified locations such as work sites, all Contract documents, including the Client Group Vision Contract applicable to this coverage. Contact your Client Administrator to make arrangements for a mutually agreeable time and location to review such Contract documents.

DeltaVision®

Administrative Offices
500 Washington Ave S, Suite 2060
Minneapolis, MN 55415
612-224-3300
Network Administrator: EyeMed (866) 485-0684
www.DeltaDentalMN.org

DeltaVision®
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DeltaVision® ***is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI"). Health care includes vision care.***

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your Vision Provider(s) for treatment purposes. For example, your Vision Provider may wish to provide a vision service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of vision services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your vision benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In other situations, not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at https://member.eyemedvisioncare.com/deltavisionmn/en or www.DeltaDentalMN.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

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TABLE OF CONTENTS

DEFINITIONS

Please find the definitions to commonly used terms related to vision services.

Anti-reflective coating – By allowing more light into your eye, anti-reflective (AR) coatings are designed to greatly reduce reflections on your lenses that can compromise visual clarity. This means you may see better. An AR coating can also help improve your night vision and make night driving safer. The reduced glare allows others to see your eyes more clearly, too.

Bifocal lenses – Bifocal lenses includes two different areas of vision correction, which are divided by a distinct line that sits horizontally across the lens. The top portion of the lens is used for distance and the bottom portion of the lens is used for closer vision.

Benefits – covered vision services provided under the terms of this policy.

Benefit Allowance – The amount DeltaVision® will pay per Covered Person towards the cost of covered vision services during a Coverage Period.

Claim – A request for payment of benefits.

Client – The party to the group Contract with DeltaVision®.

Conventional contact lenses – Contact lenses designed for long-term use (up to one year); can be either daily or extended wear.

Contract - The written agreement between the Client and DeltaVision®.

Copay – a fixed amount you pay for a covered vision service.

Coverage Period - The period of time, as determined by the Client, during which the Covered Person is enrolled with vision benefits

Covered Person(s) – the subscriber and any spouse or other dependents that are covered under this policy.

Eligible Dependents – Dependents of Eligible Employees that are eligible for coverage under the Plan.

Eligible Employee – Employees of the Client that are eligible for coverage under the Plan.

Explanation of Benefits - The DeltaVision® prepared document issued to Covered Persons and Participating Provider upon adjudication of the claim submitted for complete Vision Services provided to a Covered Person.

Digital lenses ‑ Digital lenses, also sometimes referred to as high definition or HD lenses are digitally made for accuracy and designed to provide sharper vision, improved peripheral vision and increased clarity to help colors appear more defined and details more vivid. Often, these lenses require additional measurements to personalize the lens for you.

Disposable contact lenses ‑ Contact lenses designed to be thrown away daily, weekly, bi-weekly, monthly or quarterly.

High index ‑ This super thin lens is best for those with a strong prescription. They are designed to bend light more efficiently and allow light to travel faster through them. Your eye doctor may want you to use a high-index lens depending on your prescription and the frame you choose.

Lens add-on – Any option that doesn't come with the basic lens, like polycarbonate, scratch-resistant coating, tint and UV coating. You might hear it called an "option" or "upgrade." Your EyeMed benefits cover most of the cost of these options, while you pay a copay.

Lenticular lens – Used only when a significant vision correction can't be reached with a traditional lens. This technology involves bonding one lens to the center of another to reach the correct power.

Medically Necessary Contact Lenses - Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following specific conditions:

- Keratoconus where the patient is not correctable to 20/30 in either both eyes using standard spectacle lenses.
- High Ametropia exceeding -10 D or +10D in spherical equivalent in either eye
- Anisometropia of 3 D in spherical equivalent or more
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses correction.

Open Enrollment - The period of time during which an Eligible Employee may elect, while this Contract is in effect, to add coverage under this Contract for his or herself, or his or her Eligible Dependents.

Out-of-network (OON) provider – A professional provider who is not in our network of approved, credentialed providers.

Out-of-Network Reimbursement - the maximum amount per covered person that DeltaVision® will reimburse the member for a covered service received from an out of network provider.

Participating Provider- a Vision Provider who has signed a preferred agreement with EyeMed to participate in the Insight Network.

Photochromic lenses – Sometimes also referred to as variable tint or light-adaptive lenses, these lenses change color based on different levels of light.

Plan - The vision benefit plan selected by Client.

Plastic (basic lens material) – The most widely used lens material, because it's lighter than glass.

Polarized lenses – A common lens add-on that cuts down on glare from the sun. Ideal for driving or outdoor activities, especially water and snow sports.

Policy – the group policy issued to the employer.

Polycarbonate – A commonly used lighter, thinner material that helps your lenses resist impact.

Premium – the amount the subscriber pays to their employer for their vision benefits.

Progressive lenses – Bifocal or trifocal lenses with no lines; available in both standard and premium brands.

Provider – An optician, optometrist or ophthalmologist who offers eye care or eyewear to EyeMed members.

Subscriber – the person who has signed up for vision coverage through their Employer for DeltaVision®. If family coverage is elected, additional people covered will be listed as the subscriber's spouse or

dependents.

Scratch-resistant coating – A common lens coating that helps reduce lens scratches.

Single vision lenses – Lenses prescribed for people who only need help seeing either far away or up close (not both).

Tint – A common lens add-on that reduces the light that enters your eyes; can be added because your eye doctor recommends it or because you simply like the style.

Trifocal lenses – Lenses prescribed for people who need help seeing far away, up close and in between.

Ultra-Violet Coating (UV) – In addition to the UV protection provided by your lens material (think polycarbonate), a UV coating protects your eyes from UV light being reflected off the lens and back into your eye. Over time, prolonged exposure to these rays can be damaging to your eyes.

Vision Materials – corrective lenses and/or frames or contact lenses.

Vision Provider – an optometrist, ophthalmologist, or eye care professional licensed and otherwise qualified to provide vision care.

USING YOUR VISION PLAN

1. **The Vision Provider's Role:** Vision Providers who are Participating Providers under this policy are independent contractors. The relationship between you and the Vision Provider or Participating Provider that you select to provide your vision care is strictly that of physician and patient. DeltaVision® cannot and does not make any representations as to the quality of treatment outcomes of individual providers, whether or not they are Participating Providers, nor recommends that a particular vision provider be consulted for professional care.

2. **Claims:** All claims must be submitted within twelve (12) months of the date of service. If your vision provider is a Participating Provider, the provider must submit your claim on your behalf for it to be considered an in-network claim. If you do choose to go out-of-network *and* your plan has out-of-network benefits, you'll need to pay during the visit and then submit a claim form for reimbursement. To access the out-of-network form or to check the status of a claim, log in to the member website and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included. Claim forms are also available by calling (866) 485-0684 or by visiting our website at https://member.eyemedvisioncare.com/deltavisionmn/en.

3. **How to Find a Participating Provider:** Vision Providers who have agreed to provide treatment to patients covered by a DeltaVision® policy are called "Participating Providers". The network of Participating Providers to which you have access under this policy is the EyeMed "Insight Network". To find a Participating Provider, please visit our website, https://member.eyemedvisioncare.com/deltavisionmn/en and click on "Find an eye doctor".

   If you do not have access to the website, you may also contact our Customer Service team at (866) 485-0684, Monday through Saturday between 6:30 a.m. and 10 p.m. and on Sundays between 10 a.m. and 7 p.m., Central Time.

4. **Choosing a Vision Provider:** You may choose any Vision Provider to provide services under this policy; however, if you choose a Participating Provider, your benefits will be greater and more services will be covered under this policy.

   If you choose a Vision Provider who is NOT a Participating Provider, you will be reimbursed the

lesser of the amount listed in the "Out of Network Reimbursement" column in the Schedule of Vision Benefits below or the actual cost from the Out of network provider. Out of network reimbursements are also subject to the same Benefit Frequency limitations as Participating Providers.

5. **Your First Appointment:** During your first appointment, it is very important to advise your Vision Provider of the following information:
   - Your EyeMed Group Number (located on your vision benefit ID card)
   - The name and date of birth for yourself, your spouse and any dependent children

6. **Benefits:** This policy covers the following materials when they are provided by, or under the appropriate supervision of, a duly licensed optometrist, ophthalmologist, or eyecare professional and when customary as determined by the standards of generally accepted vision practice (the table below, the "Schedule of Vision Benefits"):

Vision Care Services	Member Cost for Participating Providers	Out of network Reimbursement*
Frames		
Any available frame at provider location	$0 Copay; $150 Allowance, 20% off balance over $150	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$30
Bifocal	$10 Copay	$50
Trifocal	$10 Copay	$70
Lenticular	$10 Copay	$70
Standard Progressive Lens	$75 Copay	$50
Premium Progressive Lens	See Fixed Premium Progressive price list	$50
Lens Options:		
UV Treatment	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Plastic Scratch Coating	$0 Copay	$12
Standard Polycarbonate – Adults	$40 Copay	N/A
Standard Polycarbonate – Kids under 19:	$0 Copay	$32
Standard Anti-Reflective Coating	$45 Copay	N/A
Polarized	20% off Retail Price	N/A
Photochromatic / Transitions Plastic	$75 Copay	N/A
Premium Anti-Reflective	See Fixed Premium Anti-Reflective Coating list	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses: *(Contact lens Benefit Allowance includes materials only)*		
Conventional	$0 Copay; $150 allowance, 15% off balance over $150	$130
Disposable	$0 Copay; $150 allowance, plus balance over $150	$130

Medically Necessary (see below for Additional information)	$0 Copay, Paid-in-Full	$210
Benefit Frequency Limitations: All frequency limitations are combined In and Out of Network. **Lenses or Contact Lenses** **Frame**	 Once every 12 months Once every 12 months	

*Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

Progressive Price List*	**Member Cost In-Network (Includes Lens Copay)**
Standard Progressive	$75 Copay
Premium Progressives as Follows:	
Tier 1	$95 Copay
Tier 2	$105 Copay
Tier 3	$120 Copay
Tier 4	$75 Copay, 80% of charge less $120 Allowance
Anti-Reflective Coating Price List *	
Standard Anti Reflective Coating	$45 Copay
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57 Copay
Tier 2	$68 Copay
Tier 3	80% of charge
Other Add-Ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75 Copay
Polarized	80% of charge

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

For a current listing of brands by tier, go to: http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf

7. **Additional Participating Provider Network Discounts:** In addition to the covered benefits listed in the Schedule of Vision Benefits, when you use a Participating Provider or U.S. Laser Network provider, you may be eligible for discounts on additional services and materials not covered by this policy. For more information on the additional discounts available to you through this policy, please contact EyeMed customer service at (866) 485-0684.

GENERAL EXCLUSIONS

1. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Services or materials provided as a result of any Worker's Compensation law; or similar legislation, or required by any government agency or program whether federal, state or subdivisions thereof.
4. Services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license.
5. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.
6. Any eye or vision examination, or any corrective eyewear required as a condition of employment.
7. Safety eyewear.
8. Services rendered after the date a covered person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the service rendered to the covered person are within 31 days from the date of such order.
9. Services rendered or materials ordered and received prior to the effective date of the covered person and/or policy.
10. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
11. Medical and/or surgical treatment of the eye, eyes or supporting structures.
12. Benefit Allowances are one-time use benefits; no remaining balance.
13. Plano (non-prescription) lenses and/or contact lenses.
14. Non-prescription sunglasses.
15. Two pair of glasses in lieu of bifocals.
16. Services or materials provided by any group benefit plan providing vision care.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Client and stated within this Vision Plan Description under Effective Dates of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;
2. Legally separated;
3. Qualified domestic partner of an eligible employee, if your employer includes domestic partner coverage and if all of the following criteria are met:
   a. are not related by blood closer than permitted under Minnesota marriage laws;
   b. are not married and do not have any other domestic partners;
   c. are at least eighteen (18) years of age and have the capacity to enter into a contract;
   d. share a residence;
   e. are jointly responsible to each other for the necessities of life and, if asked, could produce

documentation of at least three of the following items as evidence of joint responsibility:

- joint mortgage or joint tenancy on a residential lease;
- joint bank account;
- joint liabilities (e.g., credit cards or car loans);
- joint ownership of significant property (e.g., cars, land, etc.)
- naming of each other a primary beneficiary in wills or life insurance policies;
- written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
- commitment to a long-term relationship with the intention of remaining together indefinitely.

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Children of the domestic partner of the employee (if your employer includes domestic partner coverage). NOTE: Children of a Domestic Partner are eligible only as long as the Domestic Partner is covered, and they must qualify as a Domestic Partner's dependent for Federal tax purposes.
3. Stepchildren who reside with you.
4. Grandchildren who are financially dependent on and reside with the covered grandparent.
5. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
6. Children for whom you or your spouse are the legal guardian.
7. Disabled children age 26 and older if:
    - they are primarily dependent upon you; and
    - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

EFFECTIVE DATES OF COVERAGE

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, or if you are a new employee of the Client, on the date following your company's probationary period.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a. On the date you first become eligible for coverage, if dependent coverage is provided or elected.
b. On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Client, if any.
c. On the date a new dependent is acquired if you are already carrying dependent coverage. LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for

coverage under the Program.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Client on a current basis.

If you elect coverage and subsequently drop coverage, you and any Dependents that you have covered will not be allowed to re-enroll in the plan until the next enrollment period for a period of 24 months from the date coverage was dropped.

CHANGES AFFECTING ELIGIBILITY AND SPECIAL ENROLLMENT

Your policy is intended to remain the same for the entire coverage period. During the coverage period, you will be allowed to change your policy only if you experience an eligible Family Status Change, including:

- Change in marital status, such as marriage or divorce.
- Change in the number of dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time, or beginning or ending a leave of absence.
- Change in dependent status, such as if a child reaches the maximum age under the plan.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current vision policy, but it is not consistent to drop your vision coverage altogether.

If you experience one of the following eligible Family Status Changes during the year, you have 31 days (except in the case of the birth/adoption of a child. See Effective Dates of Coverage as stated above) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

TERMINATION OF COVERAGE

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) On the date (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.

b) On the date the Program is terminated.

c) On the date the Client terminates the Program by failure to pay the required Client Subscriber payments, except as a result of inadvertent error.

d) The date the policy ends.

CONTINUATION OF COVERAGE (COBRA)

Vision benefits may be continued should any of the following events (called Qualifying Events) occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program.

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or a reduction in hours that causes the employee to become ineligible(except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage. 3. Date coverage would otherwise end.
Divorce, marriage dissolution, dissolution of domestic partnership, or legal separation	Former Spouse, former domestic partner and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Client that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

If you lose coverage, due to a termination of employment (except if the termination is for gross misconduct), retirement, leave of absence, lay-off, or reduction in hours, your employer should notify you of the option to continue coverage within 10 days after your loss of coverage. You or your covered dependents must notify your employer of divorce, legal separation, or any other change in dependent status within 60 days of the event.

You or your covered dependents must choose to continue coverage by completing, in writing, the election notice that your employer sends to you. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the client rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the client rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the client rate plus a 50 percent administration fee.

2. Second qualifying event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage

Continuation of Coverage for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

a. The expiration of the specified period of time for which Continuation of Coverage can be maintained; as mandated by applicable State or Federal law;

b. This Program is terminated by the Client Subscriber;

c. The Client Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage

Questions regarding Continuation of Coverage should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

CANCELLATION AND RENEWAL

The Program may be canceled by the Plan only on an anniversary date of the Client Vision Plan Contract, or at any time the Client fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Client have no right to continue coverage under the Program or convert to an individual vision coverage contract.

The benefits provided in this policy by providing you with 31 days prior written notice.

CLAIMS AND APPEALS

You may authorize someone else to file and pursue a claim for benefits or an appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to act on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Time Frames for Processing Claims

First American Administrators (FAA) will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Time Frames and Procedures for Appealing Claims

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal and notify you in writing of its decision.

External review: If you consider a decision to be partially or wholly adverse, you and your authorized representative have a right to submit a written request for external review to the Commission of Commerce at:

External Review Process
Minnesota Department of Commerce
Main Office, Golden Rule Building
85 7th Place East, Suite 280
St. Paul, MN 55101
Website: https://mn.gov/commerce/about/contact/
Phone: local- 651-539-1500, Greater Minnesota only- 1-800-657-3602

Mail written complaints to:
Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 280
St. Paul, MN 55101

Online Complaints: https://mn.gov/commerce/consumers/file-a-complaint/file-a-complaint

An independent entity contracted with the State will review your request. The independent entity is impartial, separate from and has no affiliation with Health Ventures Network. The external review decision will not be binding on you but will be binding on Health Ventures Network. Contact the Commissioner of Commerce above for more information about the external review process or to file a request for a review.

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTYASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
3300 WELLS FARGO CENTER | 90 SOUTH 7TH STREET
MINNEAPOLIS, MN 55402
Phone: 612.322.8713 | Fax: 402.474.5393 info@mnlifega.org

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net case surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issues to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net case surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000 the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and require continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assess insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Network Administrator: EyeMed Customer Service:
(866) 485-0684

Out of Network Claims Address:
First American Administrators, Inc.
Attn: Out of Network Claims
P.O. box 8504
Mason, OH 45040-7111

Corporate Office:
DeltaVision®
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415-1163
612-224-3300

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