

DeltaVision® Benefits Certificate

PREFERRED
BENEFIT LEVEL 102 / 202

Effective Date: 01/01/2010
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Form Number: VBSICERT - 0912

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

WELCOME TO VERATRUS BENEFIT SOLUTIONS, INC.

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

It is important that you understand all parts of this Benefits Certificate (Certificate) to get the most out of your coverage. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your family members eligible for coverage under this Certificate. *We*, *us*, and *our* refers to Veratrus Benefit Solutions, Inc.

We will interpret the provisions of this Certificate and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this Certificate. If any Benefit in this Certificate is subject to a determination of vision necessity and appropriateness, we will make that factual determination. Our interpretations and determinations are final and conclusive.

In this Certificate we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your coverage, please contact us.

To administer your Benefits properly, there are certain rules you must follow. Different rules appear in different sections of your Certificate. We urge you to become familiar with the entire Certificate.

DeltaVision® Contact Information

Benefits & Claims Information

Contact Customer Service for questions concerning Benefits and claims payments.

Available Hours: **Monday – Saturday 7:00 AM – 6:00 PM**, **Sunday 10:00 AM- 3:00 PM (CST)**
Toll-free: **1-888-899-3747**

Eligibility & Enrollment Updates

Please contact your Employer or Group Sponsor or call DeltaVision's Group Administration Department for address changes, or any other information changes related to member eligibility and enrollment.

Available Hours: **Monday – Friday 8:00 AM to 4:30 PM (CST)**
Toll-free: **1-877-983-3582**

Provider Locations

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

www.deltadentalia.com/deltavision

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SUMMARY OF BENEFITS CHART

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

Benefit Frequency	
Contact Lenses	Once within a 12 month period defined by last date of service.
Exam	Once within a 12 month period defined by last date of service.
Frame	Once within a 24 month period defined by last date of service.
Lens	Once within a 12 month period defined by last date of service.

Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Exam		
Exam	$10 Copay	Up to $35
Dilation	$0	N/A
Eye Exam Refraction	$0	N/A
Lens		
Single Vision	$10 Copay	Up to $25
Bi-focal	$10 Copay	Up to $40
Tri-focal	$10 Copay	Up to $55
Standard Progressive Lens	$75	Up to $40
Premium Progressive Lens	$75, 80% of Charge less $120	Up to $40
Lenticular	$10	Up to $55
Other Lens Type	80% of Charge	N/A
Frame		
Frame	80% of Balance over $130	Up to $65
Lens Options		
Standard Polycarbonate	$40	N/A
Standard Plastic Scratch Coating	$15	N/A
Tint	$15	N/A
UV Treatment	$15	N/A
Standard Anti-reflective (a/r) Coating	$45	N/A
Other Lens Options	80% of Charge	N/A
Contact Lenses		
Contact Lens- Conventional	85% of Balance over $130	Up to $104
Contact Lens- Disposable	Balance over $130	Up to $104
Standard Fit And Follow Up	$0	Up to $40
Premium Fit And Follow Up	$0 Copay, 10% off Retail Price, then apply $55 Allowance	Up to $40
Medically Necessary Contacts	$0	Up to $200
Non-Scheduled Items		
Doctor Misc. Material	80% of Charge	N/A
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	N/A

Benefit Frequencies are determined by date of service, not calendar year.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

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

IMPORTANT INFORMATION

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

UNDERSTANDING BENEFITS CERTIFICATE VOCABULARY

"Allowance" or "Allowable Expense" means the amount or percentage available for a single application toward the cost of covered vision services and materials.

"Aniseikonic Lenses" are lenses specially designed to correct spatial perception when there is a difference in retinal image size of the same object between the two eyes.

"Benefit" or "Benefits" means those vision services or procedures that are covered by DeltaVision under the terms of your Employer's Contract as specified in the SUMMARY OF BENEFITS CHART and subject to the exclusions, terms, and conditions contained in this Benefits Certificate.

"Copay" or "Copayment" means the dollar amount or percentage as shown on the SUMMARY OF BENEFITS CHART that the Eligible Member is required to pay directly to an In-Network Provider for a service or product received that is a Benefit under the contract.

"Effective Date" means the date your vision coverage begins.

"Eligible Member" is an Employee who has met the Employer's eligibility requirements and the Employee's spouse or eligible dependent child(ren).

"Employee" means an individual actively employed by the Employer for purposes of Social Security laws or who otherwise is included as a member of staff as required by law (or a member of the Board of Directors of an Employer).

"Employer" or "Employer Group" or "Group Sponsor" is the particular employing individual, agency, corporation, partnership, or company, or that particular association or trust which has entered into this agreement to provide vision coverage to its Eligible Employees or Eligible Members and is responsible for appointing a Plan Administrator for the Group Vision Program.

"In-Network Provider" means a vision care Provider who has entered into an agreement to provide Benefits to Eligible Members.

"LASIK" is Laser-Assisted In Situ Keratomileusis, a type of laser eye procedure used to treat various refractive or focusing errors of the eye. LASIK creates a flap that is opened to expose inner corneal tissue for reshaping, thereby eliminating (or reducing) the corneal refractive error and significantly changing the requirement for corrective eyewear.

"Out-of-Network Provider" means a vision care Provider who is not an In-Network Provider.

"Out-of-Network Reimbursement" is the amount that the program is contractually obligated to pay for the covered services submitted by an Eligible Member who received services from an Out-of-Network Provider.

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

"PRK" is Photo-Refractive Keratectomy, a type of laser eye procedure used to treat various refractive or focusing errors of the eye. PRK reshapes tissue on the surface of the cornea, thereby eliminating (or reducing) the corneal refractive error and significantly changing the requirement for corrective eyewear.

"Provider" is any licensed Optometrist, Ophthalmologist and/or dispensing optician.

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

"Copay or Copayment" is the dollar amount or percentage, as shown on the SUMMARY OF BENEFITS CHART, that the Eligible Member is required to pay directly to an In-Network Provider for a service or product received that is a covered Benefit under the contract. The Copayment is applied to the contracted fee for Benefits with the In-Network Provider, or to be applied to the amount in excess of the Allowable Expense for covered Benefits, whichever is applicable.

HELPING WHEN YOU HAVE QUESTIONS

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

BENEFITS (COVERED VISION PROCEDURES)

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

Benefits are subject to the limitations described in the SUMMARY OF BENEFITS CHART and the exclusions outlined in this DeltaVision Certificate. We will pay up to the Allowance shown in the SUMMARY OF BENEFITS CHART for Benefits. Eligible Members will be responsible for any remaining amount.

Some procedures may require documentation before you receive Benefits (refer to section NOTIFICATION/DOCUMENTATION REQUIREMENTS).

Eligible Members will also be responsible for any vision care products and services that are not Benefits under the contract regardless of whether the vision care services were provided by an In-Network Provider or an Out-of-Network Provider.

SERVICES NOT COVERED

This DeltaVision Certificate does not provide Benefits for vision services listed in this section.
Please note: Even if the service is not specifically listed as an exclusion, it may not be covered under this Certificate.

Certificate Exclusions And Limitations

Benefits Are Not Provided For Services or Materials Arising From:

Aniseikonic Lenses

Benefits Combined
Benefits may not be combined with any discount, promotional offering or other group Benefit plans.

Brand Names
You are not covered for certain brand name vision materials in which the manufacturer imposes a no-discount practice.

Broken Appointments
You are not covered for any fees charged because of broken appointments.

Charges for Consultation

Drugs
You are not covered for prescription, non-prescription drugs, or medicines or therapeutic drug injections.

Effective Date
You are not covered for services or supplies received before the Effective Date of coverage under this Certificate.

Employment
You are not covered for corrective eyewear required by an Employer as a condition of employment, and safety eyewear unless specifically covered under your plan.

Experimental or Investigative
You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

Eye Surgery
You are not covered for medical and/or surgical treatment of the eye, eyes, or supporting structures (except as noted on the SUMMARY OF BENEFITS CHART or Notification/Documentation Requirements).

Government Programs
You are not covered for services or supplies when you are entitled to claim Benefits from governmental programs (except Medicaid).

Incomplete Services
You are not covered for vision services that have not been completed.

Lost, Broken, or Stolen Lenses, Frames, Glasses or Contact Lenses
Lost, broken, or stolen lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.

Military Service
You are not covered for services or supplies which are required to treat an illness or injury while you are on active status in the military services.

Orthoptic or Vision Training, Subnormal Aids, and Any Associated Supplemental Testing

Payment Accountability
You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Certificate, you would not be charged.

Plano Nonprescription Lenses and Nonprescription Sunglasses

Procedures Not Specifically Covered Under This Contract

Remaining Balance
Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Termination Date
You are not covered for treatment received after the coverage termination date of this Certificate, except when Vision materials ordered before coverage ended are delivered, and the services rendered to the Eligible Member are within 31 days from the date of such order.

Timely Benefit Submission
You are not covered for services or supplies submitted more than 365 days after the services were rendered.

Treatment By Other Than A Licensed Eye Care Provider
You are not covered for services or treatment performed by anyone other than a licensed eye care Provider, or his or her Employees.

Two Pair of Glasses In Lieu of Bifocals

Vision Care Injuries or Disease
You are not covered for vision care injuries or disease caused by riots or any form of civil disobedience if the Eligible Member was a participant therein; war or act of war or terrorism; injuries sustained while in the act of committing a criminal act, injuries intentionally self-inflicted; and injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting therefrom.

Workers' Compensation
You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your Employer's Workers' Compensation coverage.

NOTIFICATION/DOCUMENTATION REQUIREMENTS

LASIK and PRK Vision Correction

LASIK and PRK Vision Correction are elective procedures, performed by specially trained Providers. To receive Benefits, members must first call 877-5LASER6 for information on the nearest facility and to receive authorization for the discount. Any discount off retail or promotional price for LASIK or PRK vision correction may not always be available from a Provider in your immediate area.

Medically Necessary Contacts

Medically necessary contacts require documentation of medical necessity from the Provider. In-Network Providers should include the required documentation with the claim submission. If service is provided by an Out-of-Network Provider documentation of medical necessity should be included with the claim form submitted by you. (See FILING CLAIMS section.)

FILING CLAIMS

Once you receive services, we need to receive a claim to determine the amount of your Benefits. The claim lets us know the services you received, when you received them, and from which Provider. You will need to file a claim only when using an Out-of-Network Provider. All In-Network Providers will submit claims for you.

WHEN TO FILE YOUR CLAIM

After you receive services, you should file a claim. Submission of claims should be made within thirty (30) days unless it is not reasonably possible to do so. Claims received more than 365 days after the services were rendered will not be considered for Benefit.

You should file a claim only *after* services are rendered. Do not file for payment before you receive a service. For Out-of-Network claim submissions, you must complete and sign an Out-of-Network claim form and include itemized paid receipts for the services and materials received on the date of service. The complete information should be mailed to the address provided. If you need a claim form or have any questions after reading this section, please contact us or visit our website www.deltadentalia.com/deltavision. If you must file your own claim, send it to the following address:

DeltaVision
Attn: OON Claims
P O Box 919
Ankeny, IA 50021

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when a person has vision care coverage under more than one plan. The COB rules determine which plan will pay as the primary plan. The primary plan pays first without regard to any

other vision care coverage that is also in effect. A secondary plan pays after the primary plan, and Benefits may be reduced so that payments from all group plans do not exceed 100% of the total Allowable Expense. Your DeltaVision plan considers itself the primary plan, and will coordinate as the secondary plan if you submit a claim that indicates another plan has already paid as the primary plan.

What You Should Do

When you receive vision services, you need to let your provider know if you have other coverage. Other coverage includes: group insurance, other group coverage (such as HMOs, PPOs, and self-insured programs); Medicare or other governmental coverage; and the medical coverage in your automobile insurance (whether issued on a fault or no-fault basis). To help us coordinate your Benefits, you should:

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

What We Will Do

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

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

DeltaVision
Attn: Claims
P O Box 919
Ankeny, IA 50021

APPEALING A DENIED CLAIM

Your Initial Request For a Review

If part or all of the services submitted on your claim have been denied, and you think the service should be covered, you or your representative can ask for a full and fair review of that claim. To file for a review, submit a request within 180 days of receiving the notice of Benefit denial, including the reason why you disagree with the claim decision, and any documents, records or any other information related to the claim. The Eligible Member's name, identification number, and the patient's name should be included on all documents.

Our Reply

Within 30 days of receiving your request, we will send you our written decision and indicate any action we have taken. However, when special circumstances arise, we may require 60 days. We will notify you in the event we require additional days.

Reviewing Records

Upon your request, we will provide you free of charge, access to and copies of all documents, records and other information relevant to your claim for Benefits. You can review records that deal with your request from 8:00 a.m. to 4:30 p.m., Central Standard Time, Monday through Friday, at our office in Ankeny, Iowa location. Since so many records are electronically filed, please call us in advance so we can have copies ready for you.

Send your request to:

DeltaVision
Attn: Quality Assurance Dept.
P O Box 919
Ankeny, IA 50021

YOUR CERTIFICATE

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any application you submitted to us or to your Employer or Group Sponsor, any agreement or group policy we have with your Employer or Group Sponsor, any application completed by your Employer or Group Sponsor, this Benefits Certificate, and any riders or amendments. All of the statements made by your Employer or Group Sponsor or you in any of these materials will be treated by us as representations to us upon which we may rely. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

ELIGIBLE MEMBERS

An Eligible Member is an Employee who has met the Employer's eligibility requirements and the Employee's spouse or eligible dependent child(ren).

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

- The child is *not married* and is a full-time student. For an eligible child to be considered a full-time student they must be enrolled in an accredited institution of higher learning, such as a college, university, nursing school, or trade school, and carry 12 or more hours per semester. Full-time student status continues during regularly scheduled school vacation periods; and during absence from class in which enrolled for up to four months due to a physical or mental disability. Veratrus Benefit Solutions, Inc. may require the disability be substantiated by a written statement from a physician.
- The child is not married and is both under age 25 and is a resident of Iowa.
- The child is a dependent of the child's parent and is totally or permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student under 25 years of age, and the dependent child must have had continuous qualifying vision coverage without a break of 63 days or more since the child turned age 19 or while the child was a full-time student under age 25.

A dependent child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

LATE ENTRANT AND RE-ENROLLMENT PROVISIONS

If you decline coverage (for yourself or your eligible dependents) when you are initially eligible as determined by your Employer Group's enrollment guidelines, you are not eligible for this coverage except as follows:

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

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

TYPES OF COVERAGE

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

- With *single coverage*, the plan member is the only one covered.
- With *Employee and spouse coverage*, the plan member and his or her spouse, are covered.
- With *Employee and child(ren) coverage,* the plan member and his or her eligible dependent child(ren) are covered.
- With *family coverage*, the plan member, his or her spouse, and each of his or her eligible dependent children have coverage. Each covered family member must be listed on the plan member's vision application for coverage or added later following a qualifying event.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If you have a dependent child and your Employer receives a Medical Child Support Order recognizing the child's right to enroll in this Benefit plan, your Employer will promptly notify both you and the dependent that the order has been received. Your Employer also will inform you and the dependent of the Employer's procedures for determining whether the order is a Qualified Medical Child Support Order.

To be a Qualified Medical Child Support Order, the Medical Child Support Order must clearly specify:

- your name and last known mailing address, if any;
- the name and mailing address of the dependent specified in the court order;
- a reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined;
- the period to which the order applies; and
- the name of each plan to which the order applies.

Also, a Qualified Medical Child Support Order cannot require that a Benefit plan provide any type or form of Benefit or option not otherwise provided under the plan, except as necessary to meet the requirements of Iowa Code Chapter 252E (1995) or Social Security Act Section 1908 with respect to group plans.

Within a reasonable time after receiving the order, your Employer will decide whether the court order is a Qualified Medical Child Support Order and will notify you and the dependent of that determination.

Once your Employer decides that a court order is a Qualified Medical Child Support Order, the order is binding on both the Employer and us, meaning that the dependent is eligible to enroll under the applicable terms and conditions of the plan as well as our standard enrollment guidelines. Your Employer must allow enrollment of the dependent regardless of any enrollment season restrictions that normally apply. Also, your Employer must forward a copy of the order to us and ask that we enroll the dependent in the plan.

Within 60 days of our receipt of either the order or the application, whichever comes first, we will decide whether the dependent is eligible for enrollment and will notify your Employer of the dependent's eligibility status. If your Employer offers more than one plan, your Employer will enroll the dependent in the same plan in which you are enrolled or a selected plan that is accessible to the dependent.

The dependent's eligibility for and enrollment in the plan will be governed by all applicable terms and conditions, including, but not limited to, eligibility standards. If eligible, the dependent will receive the same coverage that you do and will be allowed to enroll immediately regardless of normal enrollment procedures. Your Employer will withhold your share, if any, of the dependent's premiums from your compensation and forward this amount to us.

Within 30 days of receiving the order, your Employer must tell both you and the dependent that:

- the dependent has been enrolled in a Benefit plan; or
- the dependent is ineligible for enrollment and why; or
- the order has been forwarded to us without a determination of the dependent's eligibility.

If the dependent enrolls in a Benefit plan, your Employer will provide all the following information to you and the dependent:

- The name of the insurer providing the coverage.
- The dependent's Effective Date of coverage.
- The policy or account number.
- The type of coverage under which the dependent has been enrolled, including whether dental, vision, office visits, and prescription drugs are covered services.
- A brief description of the applicable deductibles, coinsurance, and other significant terms or conditions materially affecting the coverage.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of EOBs, checks, and other materials.

If your Employer decides that the order is *not* a Qualified Medical Child Support Order, each dependent specified in the order as entitled to enroll in the Benefit plan may submit a written appeal to your Employer. Within 30 days of receiving the appeal, your Employer will respond in writing.

Your Employer may not revoke enrollment or eliminate coverage for a dependent unless the Employer has received satisfactory written evidence of any of the following conditions:

- The court or administrative order requiring coverage in a Benefit plan is no longer in effect.
- The dependent child's eligibility for, or enrollment in, a comparable Benefit plan that takes effect on or before the date the dependent child's enrollment in this plan terminates.
- The Employer's elimination of dependent coverage for all Employees.

Your Employer is not required to maintain coverage for the dependent if:

- You are no longer paying premiums because your Employer no longer owes you compensation; or
- You have terminated employment with the Employer and have not elected to continue coverage.

WHEN COVERAGE BEGINS

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

Please note: Before you receive Benefits under this Certificate, you have agreed in your application for coverage (or in documents kept by us or your Employer or Group Sponsor) to release any necessary information requested about you so we can process claims for Benefits. You must allow any Provider or his or her Employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your Benefits may be denied.

If you fraudulently use your Certificate or misrepresent or conceal material facts in your application, then we may terminate this Certificate.

WHEN COVERAGE ENDS

Your eligibility for coverage will terminate at the end of the month for any of these reasons:

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

Your coverage may end if any of the following occurs:

- You use this Certificate fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
- You or your Employer or Group Sponsor fail to make payments to us when due.

Authority to Terminate, Amend, or Modify

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

CONTINUED COVERAGE (COBRA)

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

Coverage Continuation Under Federal Law — COBRA

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

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

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

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

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

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

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

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

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

Length of Coverage under COBRA

Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable.

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

Premiums

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

EVENTS CHANGING COVERAGE

Certain events may require you to change who is covered by this Certificate. These events include:

Active Duty in the Military of a dependent child or spouse.
Appointment as a Legal Guardian of a child.
Birth or Adoption of a child.
Care of a Foster Child (when placed in your home by an approved agency).
Completion of Full-time Schooling of a dependent.
Death.
An Unmarried Child (who is *not* a full-time student or permanently disabled) reaches age 25.
Divorce, Annulment, or Legal Separation.
Exhaustion of COBRA Coverage.
Marriage.
Marriage of a dependent child.
Spouse or Dependent Loses Eligibility for Qualifying Vision Coverage or Employer or Group Sponsor ceases contribution to qualifying vision coverage. In this case, your spouse and any eligible, dependent children previously covered under the prior qualifying vision coverage are eligible for coverage under this Certificate.

NOTIFICATION OF CHANGE

You must notify us within 31 days of the date of the event that changes the status of your Certificate except birth or adoption of a child. Veratrus Benefit Solutions, Inc. must be notified within 60 days of the date of the event that changes the status of your Certificate for births or adoptions. You can ask your Employer or Group Sponsor to help you make this request. If a change to your Certificate is not made within 31 days of an event (except birth or adoption of a child which is 60 days), the person(s) affected may lose important coverage.

NOTICES

Notice to your Employer or Veratrus Benefit Solutions, Inc. will be considered sufficient if mailed to each party's regular office address. Notices to you, as the member, will be considered sufficient if mailed to your last known address or the last known address of your Group. It is the responsibility of your Group to notify you regarding changes or termination of your coverage.

AUTHORIZED CERTIFICATE CHANGES

No agent, Employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this Certificate. This Certificate cannot be changed except by:

- *written amendment* signed by an authorized officer and accepted by you or your Employer or Group Sponsor as shown by payment of the monthly premium.
- *our receipt of proper notification* that your marital or dependent status has changed and we receive an appropriate monthly premium in advance, then we will change your coverage to the correct coverage type. See *Types of Coverage* explained earlier in this section.

EFFECTS OF TERMINATION

If your Certificate is terminated for fraud, misrepresentation, or the concealment of material facts:

- *we will not pay* for any services or supplies provided after the date the Certificate is terminated.
- we *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- we may, at our option, *declare the Certificate void.*

If your Certificate is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we will stop Benefits the day your Certificate is terminated.

OUR RIGHT TO RECOVER PAYMENTS

If for any reason we make payment under this Certificate in error, we may recover the amount we paid.

OTHER INFORMATION

Veratrus Benefit Solutions, Inc.'s Liability

In no instance is Veratrus Benefit Solutions, Inc. liable for any conduct, including but not limited to tortuous conduct, negligence, or wrongful acts or omissions by any service Provider or other professional practitioner or their agents or Employees in the provision or receipt of health care. In no instance is Veratrus Benefit Solutions, Inc. liable for services of facilities that, for any reason, are unavailable to you.

Nonassignment

Benefits for covered services in this Certificate are for the Eligible Member(s) and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this Certificate or rights to payment without our consent will be void.

Governing Law

To the extent not superseded by the laws of the United States, this Certificate will be construed in accordance with and governed by the laws of the State of Iowa. Any action brought because of a claim under this Certificate will be exclusively litigated in the state or federal courts located in the State of Iowa and in no other.

Legal Action

No legal or equitable action may be brought against us because of a claim under this Certificate, or because of the alleged breach of this Certificate, more than two years after the end of the calendar year in which the services or supplies were provided.

Information If You Or A Member Of Your Family Is Enrolled In Medicaid

Assignment of Rights

This plan will provide payment of Benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such Benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as an Eligible Member of this plan, nor will it affect our determination of any Benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and we have a legal obligation to provide Benefits for those services, then we will make payment of those Benefits in accordance with any state law under which a state acquires the right to such payments.

YOUR ERISA RIGHTS

Your rights concerning your coverage may be protected by the Employee Retirement Income Security Act of 1974 (ERISA). Any Employee Benefit plan established or maintained by an Employer or by an Employee organization or both is subject to this federal law unless the Benefit plan is a governmental or church plan as defined in ERISA. ***If ERISA applies to your group, you will want to read this section carefully.***

Your ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- examine certain plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents at the Plan Administrator's office or at specified locations. You will not be charged to examine these documents. The latest annual report is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain copies of certain plan documents from the Plan Administrator upon written request. The Plan Administrator may request a reasonable charge for the copies.
- receive a summary of the plan's annual financial report if your Employer or Group Sponsor has 100 or more participants in your plan. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

The Responsibility of Your Employee Benefit Plan

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your Employee Benefit Plan. The people responsible are called *fiduciaries* of the plan. Fiduciaries have a duty to operate your Employee Benefit Plan prudently and in the interest of you, other plan participants, and your beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered Benefit or exercising your rights under ERISA. If your claim for a covered Benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time requirements.

Steps You Can Take to Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request the plan document from the Plan Administrator and do not receive it within 30 days, a federal court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the document, unless the document was not sent because of matters reasonably beyond the control of the Plan Administrator.

If you have a claim for Benefits which is denied or ignored (in whole or in part), you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Who to Contact When You Have Questions

If you have any questions about your plan, you should contact the Plan Administrator, i.e. your Employer or Group Sponsor. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CONTACT INFORMATION
(Claims and Benefits)

1-888-899-3747

DeltaVision Contact Information
(Enrollment and Eligibility)

1-877-983-3582