

DeltaVision[®]

Vision Plan Description

Notice to Buyer: This policy provides vision benefits only.

Term and Renewal of Policy: This policy begins on the date shown as the Effective Date shown on the Contract Application and continues through the end of the contract year (also referred to as the "Plan Year"). This policy is renewable at the option of Red Tree Insurance Company, Inc. If Red Tree Insurance Company, Inc. provides written notice of non-renewal to the Contract Holder at least sixty (60) days prior to the end of the Plan Year, this policy will terminate as of the last day of the Plan Year.

Northeast Delta Dental

DeltaVision is underwritten by Red Tree Insurance Company, Inc., a Northeast Delta Dental company. Claims processing, claims service and provider network administration for DeltaVision are provided under contract by EyeMed Vision Care, LLC and its affiliate, First American Administrators, Inc.

Discrimination is Against the Law

Northeast Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Northeast Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Northeast Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Sheila Sarabia, Compliance Manager.

If you believe that Northeast Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sheila Sarabia, Compliance Manager
One Delta Drive
Concord, NH 03301
603-223-1127
TTY: 1-800-332-5905
Fax: 603-223-1035
ssarabia@nedelta.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Sheila Sarabia, Compliance Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-5700 (ATS : 1-800-332-5905).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-5700 (TTY: 1-800-332-5905).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-5700 (TTY: 1-800-332-5905)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-5700 (TTY: 1-800-332-5905).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0075-238-008-1 (رقم هاتف الصم والبكم: 1-800-332-5905).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-5700 (телетайп: 1-800-332-5905).

ध्यान दनु होस्त्पाइ ले नेपाल बोल्नहन्छ भन तपाइ को निम्त भाषा सहायता सवाहरु नःशल्क रुपमा उपलब्ध छ । फोन गर्नु होस् 1-800-332-5700 (ट ट्वाइ : 1-800-332-5905) ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-5700 (TTY: 1-800-332-5905).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-832-5700 (TTY: 1-800-332-5905) まで、お電話にてご連絡ください。

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-832-5700 (TTY: 1-800-332-5905).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-5700 (TTY: 1-800-332-5905) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-832-5700 (TTY: 1-800-332-5905).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-832-5700 (TTY: 1-800-332-5905).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-832-5700 (TTY: Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-332-5905).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-5700 (TTY: 1-800-332-5905).

TABLE OF CONTENTS

I.	Definitions.....	1
II.	Eligibility.....	2
III.	How to File a Claim.....	3
IV.	Your DeltaVision Benefits.....	4
V.	Exclusions and Limitations.....	4
VI.	Continuation of Benefits	5
VII.	Coordination of Benefits.....	9
VIII.	Claim Appeal Process	9
IX.	General Conditions.....	10
X.	Statement of ERISA Rights.....	12

Welcome to DeltaVision

Welcome to your DeltaVision benefits coverage, which is underwritten by Red Tree Insurance Company, Inc. ("RTIC"), a Northeast Delta Dental company. Claims administration, claims service and provider network administration are provided under contract by EyeMed Vision Care, LLC and its affiliate First American Administrators, Inc. Other administration and services are provided for RTIC, by Delta Dental Plan of New Hampshire, Inc., d/b/a Northeast Delta Dental.

Your employer has selected DeltaVision as your vision benefits plan. This Vision Plan Description and your Outline of Coverage, together describe your vision care benefits plan. Please review these documents carefully to make best use of your benefits. These benefits are provided pursuant to a Group Contract with your employer and, in the case of a conflict between the terms of the Group Contract and either your Vision Plan Description or your Outline of Coverage, the terms of the Group Contract will control. You may examine the Group Contract by contacting your employer.

EyeMed Vision Care maintains an extensive national network of well-known, quality providers of vision care services and products. To receive the greatest value for your DeltaVision coverage, visit a Network Provider for your vision care needs.

I. Definitions

When used with initial upper case (capital) letters, the words or phrases below will be defined as follows:

- A. **Benefits:** those products or services which are covered for payment, in whole or in part, under the terms and conditions of this DeltaVision benefits program and specifically referenced in your Outline of Coverage.
- B. **Contract Holder:** the group named in the contract application.
- C. **DeltaVision:** the product name for your vision services program.
- D. **Dependent:**
 - (a) the spouse to whom the Subscriber is legally married; and/or
 - (b) the domestic partner of the Subscriber; and/or
 - (c) a child of the Subscriber or of the spouse or Domestic Partner of the Subscriber, by natural birth or legal adoption or a child in the process of adoption or guardianship, a foster child legally placed by order of a court or agency having competent jurisdiction and/or a stepchild, provided such child is under the age of twenty-six (26).

Qualified children are eligible regardless of student status and coverage will terminate when a child reaches the age of twenty-six (26). Children incapable of self-support because of physical or mental disability are eligible regardless of age; supporting documentation from a health-care provider may be requested.

A newborn child is automatically covered for the first thirty-one (31) days following birth. Coverage will continue if the child is formally enrolled within the first sixty (60) days following birth or the child may be enrolled thereafter at any open enrollment or as of the first day of the month following the month of the child's first birthday.

- E. **Domestic Partner:** a Subscriber's unmarried partner of the same sex or opposite sex (and their dependents) so long as the following requirements are met:
 - 1. both parties are each other's sole Domestic Partner;
 - 2. neither is married to, or the partner in a civil union of, anyone;
 - 3. both are age eighteen (18) or older and mentally competent;
 - 4. both have joint responsibility for one another's common welfare and basic needs; and

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- 5. neither is the other's parent, child, sibling, grandparent, or any other blood relation which would bar marriage under the laws of the state in which the employee Domestic Partner resides.
 - F. **Effective Date:** the date on which the coverage of an eligible individual begins. The Effective Date of your coverage, or the coverage of a Covered Dependent, is the date specified in Section 4 (Eligibility and Enrollment) of your Employer's Group Contract.
 - G. **Group Contract:** the written agreement between your employer Red Tree Insurance Company to provide this DeltaVision benefits program.
 - H. **Network Provider:** a provider of vision care products or services who is a part of the EyeMed Vision Care network at the time services or products are provided.
 - I. **Non-Network Provider:** a provider of vision care products or services who is not a part of the EyeMed Vision Care network at the time services or products are provided.
 - J. **Outline of Coverage ("OOC"):** the insert to this VPD booklet which describes your DeltaVision service and product Benefits.
 - K. **Plan:** this vision benefits program underwritten by Red Tree Insurance Company, Inc. and administered under contracts with Delta Dental Plan of New Hampshire, Inc. d/b/a Northeast Delta Dental, EyeMed Vision Care, LLC and its affiliate, First American Administrators, Inc.
 - L. **Retiree:** a person who is retired from service to the Contract Holder and is certified by the Contract Holder as eligible for participation in this vision benefits program.
 - M. **Subscriber:** any person who:
 - 1. renders service to the Contract Holder as a paid employee, and
 - 2. is certified by the Contract Holder as a member of the group specified in the application, and
 - 3. enrolls in the group's DeltaVision benefit program.
 - N. **Vision Plan Description ("VPD"):** this document, together with the OOC, provides the Benefits and terms and conditions under which your DeltaVision program will be administered.

II. Eligibility

- A. To be eligible to receive Benefits under this DeltaVision plan, a person:
 - 1. must meet the requirements of either "Subscriber" or "Dependent" as defined in Section I (Definitions) of this VPD; and
 - 2. be currently enrolled as a Subscriber or Dependent.
- B. The Effective Date of a person's eligibility shall be determined by the provisions of the Contract Holder's Group Contract. Please consult with your employer if you have any questions regarding the Effective Date of coverage.
- C. Subject to federal continuation of coverage (COBRA) provisions (see Article VI, Continuation of Benefits Under Federal COBRA Law) if applicable, termination of a Subscriber's or Dependent's eligibility will occur on the earliest of:
 - 1. the last day of the month in which the Subscriber ceases to be a Subscriber;
 - 2. the date of termination of this agreement;
 - 3. the last day of the month in which a Dependent no longer qualifies as a Dependent;
 - 4. the last day of the last month for which payment has been made to Northeast Delta Dental by Contract Holder.

III. How to File a Claim

A. When Using a Network Provider

To receive your vision Benefits when visiting a Network Provider, follow these easy steps:

1. Present your DeltaVision identification card to your provider or give the provider your name and your date of birth.
2. Your provider will confirm your eligibility for DeltaVision Benefits. There is no prior authorization requirement for covered services or products, including emergency services.
3. Receive your vision services or products and your provider will calculate any out-of-pocket expenses remaining after your Benefits have been applied. Out-of-pocket expenses may include copayments, any amounts in excess of applicable allowances as outlined on your OOC, and any amounts due for non-covered services or products. There is no deductible on this DeltaVision Plan.
4. Pay your out-of-pocket expenses at the time you receive your services or products.
5. Your provider will handle the rest.

B. When Using a Non-Network Provider

To receive vision benefits if you visit a Non-Network Provider, follow these steps:

1. Pay in full for the vision products and services you receive from your Non-Network Provider at the time of your visit.
2. Obtain an itemized receipt from the provider.
3. Obtain an EyeMed claim form either by calling EyeMed (866-723-0513) or downloading the form from the EyeMed Website (www.eyemedvisioncare.com) or from the Northeast Delta Dental Website (www.nedelta.com).
4. Submit your total claim on the EyeMed claim form, attaching your itemized receipt (keep a copy for your records).
5. EyeMed will reimburse you for your out-of-network DeltaVision Benefits.

C. Claim Forms and Payment

Written notice of sickness or of injury must be given to EyeMed or Northeast Delta Dental within thirty (30) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

A claim (or satisfactory written proof acceptable to EyeMed) must be furnished to EyeMed at its principal office within twenty-four (24) months from the date the vision services were provided. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation except for a demonstrated reason preventing submission within the twenty-four (24) month period.

Benefits will be paid directly to the provider if the provider participates with EyeMed. If the provider does not participate with EyeMed, payment will be made to the Subscriber unless the state in which the services are rendered requires that assignments of benefits be honored and EyeMed receives written notice of an assignment on the claim form before payment for benefits is made.

EyeMed or Northeast Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this policy with the time fixed in the policy for filing claims. Notice given by or on behalf of you to Northeast Delta Dental, or to any authorized agent of Northeast Delta Dental, with information sufficient to identify you, shall be deemed notice to Northeast Delta Dental.

IV. Your DeltaVision Benefits

Only those vision care products and services listed on your Outline of Coverage are covered under your Group Contract. Your Benefits are subject to the terms, limitations and exclusions provided in the Outline of Coverage (OOC) and the exclusions and limitations contained in Section V (Exclusions and Limitations) of this Vision Plan Description (VPD). **READ YOUR VPD and OOC CAREFULLY to understand your plan and receive the greatest value for your Benefits.**

Remember - the Subscriber or covered Dependent will be responsible for payment for any vision services or products received that are not Benefits under this Plan, regardless of whether such services or products are received from a Network or Non-Network Provider.

V. Exclusions and Limitations

Your DeltaVision Benefits are subject to the following:

A. **Exclusions:** The following are not Benefits under your DeltaVision Plan:

1. Services or products received prior to the Effective Date of the Subscriber's or Dependent's coverage or after the termination date of such coverage.
2. Any service or product to treat injuries or conditions compensable under worker's compensation or employer's liability laws.
3. Any services or products not specifically provided as a Benefit in the Outline of Coverage under the Group Contract.
4. Corrective eyewear required as a condition of employment and safety eyewear unless specifically covered under this Plan.
5. Plano (clear) non-prescription lenses and non-prescription sunglasses.
6. Charges for consultations and for completion of forms.
7. Orthoptic or vision training, subnormal vision aids and any associated testing.
8. Aniseikonic lenses (for unequal size retinas).
9. Medical and/or surgical treatment of the eye, eyes or supporting structures.
10. Lost or broken products.

B. **Limitations:** The following limitations apply to your DeltaVision Benefits:

1. Discount benefits do not apply to a Network Provider's professional services which are covered as Benefits.
2. For products received from a Network Provider but not covered as Benefits, the discount specified in the Outline of Coverage will apply; however, the discount may not be combined with any other discounts or promotional offers.
3. Lasik or PRK vision correction is an elective procedure performed by specially trained providers who are not located in all areas. The discount available for such procedures may not be available in your immediate location.
4. Discounts do not apply to benefits provided by other group benefit plans.
5. The Benefit for frames will not be available for certain brands of frames for which the manufacturer imposes a no-discount policy.
6. Benefits will not be provided for two (2) pair of eyeglasses in lieu of one pair of bifocals. If two separate pairs of eyeglasses are chosen rather than one pair of bifocals, the first pair will be covered by the Plan as a Benefit and the second pair will receive a 40% discount.

VI. Continuation of Benefits

Under certain circumstances, a person covered by an employee welfare benefit plan may be entitled, under applicable state and/or federal law (COBRA), to continue his or her group coverage for a specified period of time. To determine whether this DeltaVision benefits plan is subject to continuation, please contact your employer. If your employer is subject to the COBRA continuation of benefits requirements, please read the following.

Federal Law Rights to Continue Coverage

Upon termination of coverage under this vision benefits plan, former Subscribers and/or eligible Dependents may be eligible, under federal law (COBRA) to continue group coverage benefits, depending upon certain conditions contained in this law. If a former Subscriber or eligible Dependent elects to continue coverage under the federal statute if applicable, the group under which benefits were formerly provided will be responsible to collect the applicable premium from the persons electing coverage. The federal law will govern administration of the continuation coverage. Rights under that statute are provided below:

Rights Under the Federal Statute (COBRA) (if applicable):

Federal law requires most employers sponsoring group health plans to offer Subscribers and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances in which coverage under a group health plan would otherwise end. For simplicity, your group vision plan is referred to in the Notice from the employer as the “Plan.” The Plan administrator of your plan should provide the COBRA notice of eligibility for COBRA coverage within fourteen (14) days of receiving notice of a qualifying event. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage. At the end of the maximum coverage period (described below), there is no individual conversion vision plan available under the Plan. The Notice provides a brief overview of your rights and obligations under current law. This Plan offers no greater COBRA rights other than those the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the employee) and your spouse or Domestic Partner should read this summary carefully and keep it with your records!

Qualifying Events

If you are a Subscriber and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of either one of the following two “qualifying events”:

- A. Termination of your employment (for reasons other than gross misconduct).
- B. Reduction in the hours of your employment.

If you are the **spouse** of a Subscriber covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four “qualifying events”:

- A. The death of your spouse.
- B. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the employer.
- C. Divorce or legal separation from your spouse (Also, if a Subscriber eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

D. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of a Subscriber covered by the Plan, he or she has the right to elect continuation coverage if group vision coverage under the Plan is lost because of any of the following five “qualifying events”:

1. The death of the Subscriber parent.
2. The termination of the Subscriber parent’s employment (for reasons other than gross misconduct) or reduction in the Subscriber parent’s hours of employment with the employer.
3. Parents’ divorce or legal separation.
4. The Subscriber parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a “dependent child” under the Plan.

Your IMPORTANT Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child’s losing dependent status under the Plan, then under the COBRA statute, you (the Subscriber) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child’s losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the Plan (see this summary plan description for details regarding when Plan coverage terminates.) *If you or your spouse or dependent fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child’s losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with notice of a divorce, legal separation, or a child’s losing dependent status that has caused a loss of coverage, then the Plan Administrator will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member’s current mailing address—see the “YOU MUST PROVIDE NOTIFICATION OF CHANGES...” section on page 9).

You (the Subscriber) and your spouse and dependent children will also be notified of the right to elect continuation coverage upon the following events that result in a loss in coverage: the Subscriber’s termination of employment (other than for gross misconduct), reduction in hours, or death, or the Subscriber’s becoming entitled to Medicare.

Election Procedures

You (the Subscriber) and/or your spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be made on the date of the mailing.

You (the Subscriber) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered Subscriber does not (or is not deemed to) elect it.

You (the Subscriber) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group vision plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, a Subscriber, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as a divorce. If the coverage is modified for similarly-situated Subscribers or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have coverage. For example, if you are covered under three separate employer plans, a medical plan, a vision plan, and a dental plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the vision and dental plans. But if the employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

COBRA Premiums You Must Pay

The premium payments for the “initial premium months” must be paid for you (the Subscriber) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month’s premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you don’t make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA can be cut off before the maximum period expires in certain situations described later under the heading “Termination of COBRA Before the End of the Maximum Coverage Period.”

36 Months. If you (the spouse or dependent child) lose group vision coverage because of the Subscriber’s death, divorce, legal separation, or the Subscriber’s becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the Subscriber, spouse or dependent child) lose group vision coverage because of the Subscriber’s termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for the Subscriber, spouse and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:

- If a Subscriber or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of the termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental
- Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination.

- If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the Subscriber dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours.
- If the qualifying event occurs within 18 months after the Subscriber becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends three years from the date the Subscriber became entitled to Medicare.

Children Born to or Placed for Adoption With the Subscriber During COBRA Period

A child born to, adopted by or placed for adoption with a Subscriber during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The covered employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirements (for example, regarding age). The covered employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption or placement for adoption to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the employee. (The 30-day grace period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered employee or family member fails to so notify the Plan Administrator in a timely fashion, then the covered employee will NOT be offered the option to elect COBRA coverage for the child.*

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active Subscribers to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA (the "Health Insurance Portability and Accountability Act of 1996"), a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born to or Placed for Adoption With the Subscriber After the Qualifying Event," dependents who are added under HIPAA's special enrollment rights do not become qualified beneficiaries their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Subscriber, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

- A. The employer no longer provides group health coverage to any of its employees.
- B. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
- C. After electing COBRA, you (the Subscriber, spouse or dependent child) become covered under another group vision plan (as a Subscriber or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group vision plan. (Note that under HIPAA, an exclusion or limitation of the other group vision plan might not apply at all to the qualified beneficiary depending on the length of his or her creditable vision plan coverage prior to enrolling in the other group vision plan.)

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- D. After electing COBRA coverage, you (the Subscriber, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
 - E. You (the Subscriber, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
 - F. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to Subscriber or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Provide Notification of Changes of Address, Marital Status, Dependent Status and Disability Status

If your or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator

The employer is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to the individual who is acting on behalf of the Plan Administrator.

For More Information

If you, your spouse or dependent children have any questions about this notice or COBRA, please contact the Plan Administrator. Also, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

VII. Coordination of Benefits

This Plan does not coordinate benefits, and determines and pays benefits as primary carrier.

VIII. Claim Appeal Process

How to Appeal a Claim Determination

- A. In the event that you are dissatisfied with a claim payment decision, you have the right to have the claim determination reviewed. To file an appeal of your claim (a "Claim Appeal"), please follow these steps:
 - 1. You should submit your Claim Appeal, in writing, within 180 calendar days of your receipt of the claim decision you wish to appeal, to:
EyeMed Vision Care/First American Administrators, Inc. ("FAA")
Attn: Claim Appeals
4000 Luxottica Place
Mason, Ohio 45040
Fax: (513) 765-3024
Toll Free Phone: (866) 723-0513

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2. Your written Claim Appeal should include the following:
 - (a) the claim number;
 - (b) a copy of your Explanation of Benefits (“EOB”);
 - (c) an explanation of why you feel the claim was incorrectly determined, including references to the benefit provisions you feel apply; and
 - (d) any additional information you have which may assist in the Claim Appeal process.
 3. You will be sent an acknowledgement letter within three (3) business days of FAA’s receipt of your Claim Appeal.
- B. In deciding the Claim Appeal, FAA will:
1. give no deference to the initial decision to deny the claim;
 2. have the Claim Appeal reviewed and decided by an individual who did not make the initial claim decision and who is not a subordinate of anyone who made the initial claim decision;
 3. in the event a Claim Appeal is based on medical judgment, in whole or in part, consult with a health care professional having appropriate training and experience in the relevant field and who was not involved in the initial claim decision;
 4. promptly review the Claim Appeal and all related documents and send a resolution letter to you within thirty (30) calendar days of receipt of the Claim Appeal;
 5. if the Claim Appeal decision is not favorable to you, include the following information in the claim review letter:
 - (a) the specific reason(s) for the decision;
 - (b) a reference to the plan or policy provision(s) on which the claim is based;
 - (c) a statement that you may receive, upon request and free of charge, access to, and copies of, all documents, records and information relevant to the initial claim and Claim Appeal decision;
 - (d) if an internal rule, guidance or protocol was relied upon in making the Claim Appeal decision, a statement that you may receive, upon request and free of charge, a copy of such rule, guidance or protocol; and
 - (e) if the Claim Appeal decision is based on medical necessity or a similar exclusion or limit, a statement that an explanation will be provided to you free of charge, upon your request.
 6. You are entitled to receive, upon request, a copy of any Claim Appeal documents and proceedings.
 7. You will not be subject to any adverse action or penalty due to your filing of a Claim Appeal.

IX. General Conditions

Transfer of Benefits Prohibited:

Benefits of Enrollees are personal and cannot be transferred.

Doctor-Patient Relationship:

You have the freedom to choose any provider, but will generally receive the best value from your Plan if you visit a Network Provider. The provider will be solely responsible to the patient for vision advice and treatment and any resulting liability.

Loss of Eligibility during Treatment:

If an eligible Dependent loses eligibility while receiving vision treatment, only covered services received while eligible will be considered for payment. Someone enrolled under the Plan may lose eligibility if such person ceases to be an eligible person in accordance with the provision of Section II. of this Plan.

Maintaining Your Privacy:

Northeast Delta Dental and RTIC have always respected and carefully preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained.

For a copy of RTIC's Notice of Privacy Practices which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
1-800-537-1715

Entire Agreement:

This Plan, together with the Contract Application, Outline of Coverage and additionally the Group Contract in the case of a Group Contract Holder, constitute the entire contract of insurance. No change in this Plan shall be valid unless approved by an executive officer of RTIC and evidenced by a written, signed endorsement hereto. No broker or agent has authority to change this Certificate of Insurance or waive any of its provisions.

Governing Law:

This policy is governed by and shall be construed according to, the laws of the state of New Hampshire and its regulations. This vision plan is under the jurisdiction of the Maine Insurance Commissioner.

Legal Action:

No action may be brought to recover a claim under this policy prior to the expiration of sixty (60) days after the claim has been filed or the claim review and appeal process, described in Section VIII (Claim Appeal Process) herein, has been completed. In no event shall any action be brought on a claim more than two (2) years after the completed claim has been filed.

Nonwaiver of Rights: Severability:

Failure of Northeast Delta Dental to exercise any right or remedy under this policy in any instance will not affect its right to exercise that right or remedy in any future instance. Any condition, limitation or other provision of this policy which is found to be illegal or unenforceable for any reason will not affect the remaining provisions of this policy.

Incontestability:

After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by you in the application for such policy shall be used to void the policy or to deny a claim (as defined in the policy) commencing after the expiration of such two (2) year period.

Cognitive Impairment or Functional Incapacity- Notice of Rights:

Under Maine law, a person having a mental or nervous disorder with a demonstrable organic origin causing significant cognitive impairment or functional incapacity, including, but not limited to Cognitive Impairment or Functional Incapacity") has certain rights with respect to his or her coverage under this plan. Those include the right:

- (a) to designate a third party to receive notice of cancellation of this policy;

- (b) to change the designated third party upon written request sent or given to Northeast Delta Dental;
- (c) to reinstatement of this policy if the coverage was cancelled due to non-payment of premium or other default.

Within ten (10) days of a request by an insured, Northeast Delta Dental will mail or cause to be personally delivered a Third Party Notice Request Form. In the event that coverage under this policy is to be terminated, Northeast Delta Dental shall provide, in addition to any other notice to the insured required by law, a notice of the pending cancellation to any third party properly designated by a covered person having Cognitive Impairment or Functional Incapacity. Such notice shall contain all information required by law and shall be at least twenty-one (21) days prior to the expiration of the applicable payment grace period.

If a request for reinstatement of coverage is denied, notice of denial shall be provided to the subscriber, to any third party properly designated, and to the person making the request, if different. The notice of denial shall include notification of a thirty (30) day period following the receipt of the notice during which a hearing before the Superintendent may be requested.

X. Statement of ERISA Rights

The following statement is applicable to those vision plans subject to the provisions of the Employees Retirement Income Security Act of 1974 (ERISA):

Your Rights: As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits: Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employees Benefits Security Administration.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report.

COBRA and HIPAA Rights: Continue dental coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a 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 schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not

sent because of reasons 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.

Assistance with Your Questions: If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employees Benefits Security Agency, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employees 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.

Customer Service

For claims related questions, call:

EyeMed Vision Care

866-723-0513

TDD

866-308-5375

For billing and eligibility questions, call:

Northeast Delta Dental

603-223-1234

800-832-5700

TTY/Hearing Impaired

800-332-5905

Northeast Delta Dental

One Delta Drive

PO Box 2002

Concord, NH 03302-2002

www.nedelta.com

Corporate Office

603-223-1000

800-537-1715