DELTAVISION

Dynamic Select Plus 150 Vision Plan

Member Certificate

Underwritten by: *Advantica Insurance Company*
12399 Gravois Road
St. Louis, MO 63127

Administered by: *Delta Dental of Missouri*
12399 Gravois Road
St. Louis, MO 63127

Superior Vision
11090 White Rock Road, Suite 175
Rancho Cordova, CA 95670

MO-DV-AIC-MC-10-19

DELTAVISION MEMBER CERTIFICATE

This Member Certificate explains the vision care coverage under the Master Policy issued to the Group Sponsor. The Group Sponsor information is shown on the Group Information Schedule included with this Member Certificate. This Member Certificate, including the Group Information Schedule and the Schedule of Benefits, forms the Member's certificate of coverage while the Member is covered under the Master Policy. It replaces any previous certificates of coverage issued to the Member under the Master Policy.

This Member Certificate provides a general description of the Member's vision care benefits. All benefits are governed by the terms and conditions of the Master Policy. The Master Policy together with any documents referenced therein, constitutes the entire contract between the Group Sponsor and Advantica Insurance Company ("Company"). Members may examine the Master Policy during regular business hours by contacting the Group Sponsor.

***In Witness Whereof,** Company has caused this Member Certificate to be duly executed and effective as of the Effective Date as stated in the Master Policy.*

ADVANTICA INSURANCE COMPANY

BY

President

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Section I - Definitions

"Administrator" means the entity that provides administrative services for the writing and servicing of the Master Policy. Unless otherwise designated on the Group Information Schedule, the Administrators are Delta Dental of Missouri and Superior Vision.

"Allowable Expense" means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

"Benefit Frequency" means the period during which a benefit is payable under the terms of this Member Certificate, as indicated on the Schedule of Benefits. This period will begin on January 1.

"Child" or "Children" means a person or persons described below.

(1) A Member's natural child, stepchild, or legally adopted child.

(2) An individual for whom guardianship is granted to a Member by court or testamentary appointment (other than temporary guardianship of less than 12 months duration).

(3) A child required to be covered by a Member or such Member's spouse by reason of a "qualified medical child support order" as defined by Section 609 of the Employee Retirement Income Security Act of 1974 and determined to be such by the Group Sponsor.

"Claim" means a request for payment of benefits under this Member Certificate.

"Company" means Advantica Insurance Company.

"Contact Lenses" means a thin lens designed to fit over the cornea and worn to correct defects in vision.

"Coordination of Benefits" means taking other Plans into account when Company pays benefits.

"Copay" means the portion of the costs for Covered Services or Materials for which the Covered Person is responsible for payment.

"Covered Dependent" means an Eligible Dependent who is covered under the Master Policy.

"Covered Person" means a Member and any Covered Dependent.

"Covered Services or Materials" means the Vision Examination services and Materials that qualify for benefits under the Master Policy as shown in the Schedule of Benefits.

"Elective Contact Lenses" means Contact Lenses a Covered Person chooses to wear instead of eyeglasses for reasons of comfort or appearance.

"Eligible Class" means the group of individuals who are eligible for coverage under the Master Policy as shown in the Group Information Schedule.

"Eligible Dependent" means a person described below.

(1) A Child who is under twenty six (26) years of age. Such a Child is eligible until the last day of the month in which the Child attains the limiting age.

(2) Any other unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical incapacity and who became so incapacitated before the limiting age set forth above in paragraph (1). The Member must furnish proof of such incapacity and dependency to Company within thirty-one (31) days of the dependent Child's limiting age birthday. The Company may require the Member to furnish proof of the Child's incapacity and dependency at reasonable intervals during the two years following the dependent Child's limiting age birthday. After such two-year period, the Company may require the Member to furnish subsequent proof not more than once each year.

(3) A Member's lawful spouse.

"Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Company.

"Eyeglass Frames" means a frame that includes a nosepiece for resting on the bridge of the nose and two sidepieces extending over or around the ears which holds in place two glass or plastic lenses worn to correct defects in vision.

"Eyeglass Lenses" means a standard glass or plastic (CR-39) lens, which is optically clear, that will fit an Eyeglass Frame with a lens size less than 61mm in length. Standard multi-focal lenses include segments through Flat Top 35 for plastic bifocal and lenticular lenses, through Flat Top 28 for glass trifocals and through Flat Top 35 for plastic trifocals.

"Group" means a group of Members who have been accepted and designated as such by Company, consisting of persons who are actively or formerly employed, associated or affiliated Members whose dues or service charges are remitted by the same Group Sponsor.

"Group Sponsor" means an individual, partnership, association, corporation, organization or other entity which agrees to sponsor a Group and to pay, or collect and remit to Company, the dues or services charges payable by or with respect to the Members under the Master Policy, either by payroll reduction or otherwise and to receive any notice, card, certificate or rider from Company on behalf of such Members.

"Health Care Entity" means a business entity that provides Health Care Services for the testing, diagnosis or treatment of human disease or dysfunction, or dispensing of drugs, medical devices, medical appliances or medical goods for the treatment of human disease or dysfunction.

"Health Care Practitioner" means a person who is licensed, certified or otherwise authorized to provide Health Care Services in the ordinary course of business or practice of a profession.

"Health Care Services" means medical procedures, tests and services provided to a patient by or through a Health Care Entity.

"Immediate Family Member" means a parent, stepparent, spouse, child, step-child, brother or sister. For purposes of the definition of "Prohibited Referral" below "Immediate Family Member" means a Health Care Practitioner's (1) spouse or domestic partner; (2) child; (3) child's spouse or domestic partner; (4) parent; (5) spouse's or domestic partner's parent; (6) sibling or (7) sibling's spouse or domestic partner.

"Initial Term" means the period following the Group's initial effective date and shown in the Group Information Schedule.

"In-Network Provider" means an Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide Covered Services or Materials at an agreed to cost.

"In-Network Provider Directory" means a periodically-updated list of In-Network Providers and the services they are contracted for in the Member's area.

"Late Entrant" means any Member or Eligible Dependent enrolling more than thirty one (31) days after first becoming eligible for coverage.

"Materials" means corrective Eyeglass Lenses, Eyeglass Frames and Contact Lenses.

"Medically Necessary Contact Lenses" means Contact Lenses that are prescribed solely for the purpose of correcting one of the following medical conditions, which prevent the Covered Person from achieving a specified level of visual acuity through the wearing of conventional eyeglasses: (1) Aphakia; (2) visual acuity less than 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better); (3) Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye; or (4) Keratoconus.

"Member" means a person who has made application to and has been duly accepted for coverage by Company, and who is actively employed, associated or affiliated by or with the Group Sponsor or who was previously employed, associated or affiliated by or with the Group Sponsor and remains eligible for continuation services.

"Ophthalmologist" means a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of Ophthalmology. The Covered Person's Ophthalmologist cannot be: (1) the Member; (2) an Immediate Family Member, or (3) retained by the Group Sponsor.

"Optician" means a duly licensed (if required) person or business that grinds or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Covered Person's Optician cannot be: (1) the Member; (2) an Immediate Family Member or (3) retained by the Group Sponsor.

"Optometrist" means a person licensed to practice Optometry as defined by the laws of the state in which services are rendered. The Covered Person's Optometrist cannot be (1) the Member; (2) an Immediate Family Member or (3) retained by the Group Sponsor.

"Out-of-Network Provider" means an Ophthalmologist, Optometrist or Optician who is not an In-Network Provider.

"Plan" means any plan, including this one, that provides benefits or services for vision services on either a group or individual basis; except that Company will not coordinate coverage with any individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans and plans required or provided by statute (except Medicaid). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

"Plano Lens" means a lens that has no refractive power.

"Primary Plan" means the Plan that, according to the rules for the order of benefit determination, pays benefits before all other Plans.

"Prohibited Referral" means the referral of a patient by a Health Care Practitioner, either directly or indirectly, to a Health Care Entity (1) in which the Health Care Practitioner, or the Practitioner in combination with the Practitioner's Immediate Family Member, owns a beneficial interest; (2) in which the Practitioner's Immediate Family Member owns a beneficial interest; or (3) with which the Health Care Practitioner, the Practitioner's Immediate Family Member, or the Practitioner in combination with the Practitioner's Immediate Family Member has a compensation arrangement.

"Schedule of Benefits" means the document that sets forth the extent to which benefits will be provided a Covered Person under the Master Policy. Copays, which include deductibles and coinsurance, and allowances are included in the Schedule of Benefits. Such Schedule of Benefits will be the one in effect and for which dues or service charges are being remitted at the time the service is provided.

"Re-Enrollee" means any Member or Eligible Dependent who terminated coverage and then, subsequently, re-enrolled for coverage at a later date. Benefits may be limited for Re-Enrollees. See the section entitled "Limitations and Exclusions".

"Renewal Date" means the date specified as such in the Master Policy.

"Vision Examination" means an examination of principal vision functions, which includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The examination must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

Section II – Eligibility and Enrollment

A. Eligibility.

An individual must be a Member of an Eligible Class of the Group Sponsor, as defined in the Group Information Schedule, in order to be eligible for coverage under the Master Policy. If dependent coverage is provided under the Master Policy, the Member's Eligible Dependents are also eligible for coverage.

If both a Member and his or her spouse are in an Eligible Class of the Group Sponsor, each of them may enroll individually or as a dependent of the other, but not as both. Any Eligible Dependent Child may also only be enrolled by one parent. If the spouse carrying dependent coverage ceases to be eligible,

dependent coverage automatically becomes effective under the other spouse's coverage or enrollment will default to the Group Sponsor's rules.

B. Enrollment.

Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents and paid any required premium. Members should enroll themselves and their Eligible Dependents within thirty one (31) days of first becoming eligible to enroll.

Members also may enroll themselves and their Eligible Dependents during an open enrollment period specified by the Group Sponsor, usually one time per calendar year. Other changes may also be restricted to open enrollment periods. Members who do not enroll themselves or their Eligible Dependents within the initial enrollment period are considered Late Entrants and may not enroll until the next open enrollment period unless there is a change in family status, as described below.

Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within thirty one (31) days of the event. A change in family status means any of the following events: (1) marriage; (2) divorce or legal separation; (3) birth or adoption of a child; (4) death of a spouse or child; or (5) other changes as permitted by the Group Sponsor.

If a Member's spouse has lost his or her coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause, such spouse may enroll for coverage under the Master Policy without evidence of insurability for a period of six (6) months, beginning with the date such spouse loses his or her coverage under the other group health insurance contract or policy.

Members may enroll an Eligible Dependent Child at any time and without evidence of insurability if (1) the dependent Child was previously covered under the Member's spouse's coverage; and (2) the Member's spouse has died. This provision applies regardless of whether or not such dependent Children are eligible for any continuation or conversion privileges under the spouse's coverage and enrollment of an Eligible Dependent Child pursuant to this provision must occur within six months after the death of the spouse.

If a Member, or such Member's spouse, is required under a court order to provide health insurance coverage for a Child, such Child will be eligible for enrollment at any time regardless of enrollment restrictions. If the Member does not include the Child in the enrollment, any non-insuring parent, Child Support Enforcement Agency or Department of Health and Mental Hygiene will be allowed to apply for enrollment on behalf of the Child at any time regardless of any enrollment restrictions. The coverage for such Child may not be terminated unless written evidence is provided to Company that: (1) the court order is no longer in effect; (2) the Child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination; (3) the Group Sponsor has eliminated Immediate Family Members' coverage for all of its employees; or (4) the Group Sponsor no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the Child consistent with the Group Sponsor's Plan for post-employment health insurance coverage for dependents.

If a Child is enrolled by a Member, Company will (1) provide to the non-insuring parent (if any) membership cards, claims forms, and any other information necessary for the Child to obtain benefits

provided hereunder; and (2) process the claims forms and make appropriate payment to the non-insuring parent, health care provider or Department of Health and Mental Hygiene (or similar agency) if the non-insuring parent incurs expenses for covered vision care provided to the Child.

If an eligible Member's plan requires that the eligible Member be enrolled in order for the Child to be enrolled and the eligible Member is not currently enrolled, Company will enroll both the eligible Member and the Child, without regard to enrollment restrictions, within twenty (20) business days after receipt of a Medical Support Notice from the Group Sponsor.

Section III – Effective Dates

A. Coverage of Newborns and Adopted Children.

A Child born to a Member or a Member's Covered Dependent is covered from the moment of birth to thirty-one (31) days. A notice of birth, together with any additional premium, must be submitted to Company within thirty-one (31) days of birth in order to continue the coverage beyond the initial thirty-one (31) day period.

If an application or other form of enrollment is required in order to continue coverage beyond the thirty-one (31) day period after the date of birth of a newborn child and Member has notified Company of the birth, either orally or in writing, Company will, upon such notification, provide Member with all forms and instructions necessary to enroll the newborn child, and Member will then have an additional ten (10) days from the date such forms and instructions are provided to Member in which to enroll the newborn child.

A Child adopted by a Member or a Member's Covered Dependent spouse is covered from the date of placement, unless the Child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Company within thirty-one (31) days of the placement in order to continue the coverage beyond the initial thirty-one (31) day period.

B. Other Coverage.

Provided the initial premium is paid, coverage will be effective on the later of the Effective Date (shown on the Group Information Schedule), or the date the Member meets all of the Eligibility and Enrollment requirements.

Subject to completion of the required Enrollment and payment of any required premium, for Eligible Dependents acquired after a Member's effective date of coverage, by reason of marriage, birth or adoption, coverage is effective on the date such Eligible Dependent was acquired (the date specified by the Group Sponsor).

Section IV – Premiums

A. Premium Payment.

Subject to the terms established by the Group Sponsor, Members may be required to contribute, either in whole or in part, to the cost of their coverage. Members' premium contributions, if required, are remitted to Company in one of the following two ways, indicated on the Group Information Schedule: (1) Members contribute to the cost of the coverage through the Group Sponsor, who then submits

payment to Company; or (2) Members pay premiums directly to Company. The initial premium is due on the Effective Date. Premiums after the initial premium are due on the Premium Due Date or within the Grace Period.

B. Adjustments.

Company reserves the right to change the premium rates on any Premium Due Date on or after the Initial Term. After the Initial Term, Company will not increase the premium rates more than once in a six-(6) month period, upon prior written notice to the Group Sponsor of at least forty-five (45) days. All changes in rates are subject to terms outlined in the Master Policy.

C. Grace Period.

Group Sponsor has a Grace Period of thirty-one (31) days for the payment of any premium due after the initial premium (during which time the Master Policy shall continue in force), unless the Master Policy is sooner terminated or not renewed.

Unless the Group Sponsor has given written notice to Company that coverage under the Master Policy is to terminate before the end of the Grace Period, Company will have the right to collect premium for the thirty-one (31) day Grace Period.

If Company receives a notice of Master Policy termination during the Grace Period, Company may collect premium for the period beginning on the first day of the Grace Period until the later of the date on which notice is received or the date of termination stated in the notice. The Group Sponsor will owe Company prorated premium for the time coverage was in effect during the Grace Period.

If premium for the thirty-one (31) day Grace Period is paid after the Grace Period ends, Company may charge interest for the premium, but interest may not begin to accrue during the thirty-one (31) day Grace Period and the interest rate charged may not exceed the maximum rate permitted by law.

Section V – Description of Coverage

Company pays a benefit if a Member receives Covered Services or Materials at the allowable frequency while coverage under the Master Policy is in force. A Member may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Member will generally incur less out-of-pocket cost.

A. In-Network Benefits.

When a Member enrolls for coverage, an In-Network Provider Directory will be made available to the Member with the names, phone numbers and addresses of In-Network Providers, although a provider's status may occasionally change. Company recommends that Members call the Administrator to verify the provider's participation status in the network. Members may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, Company will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Member pays any required Copay and any charges above the Covered

Services or Materials to the In-Network Provider. The In-Network Provider usually takes care of Claims submission and administrative services.

B. Out-of-Network Benefits.

If a Member chooses to use an Out-of-Network Provider, the Member must pay the provider in full for the services and materials purchased. It is the Member's responsibility to send Company a Claim by submitting the itemized original invoice or receipt (see the "Notice of Claim" provision). Any Copay that applies should not be paid to the Out-of-Network Provider, as it will be deducted by Company at the time the Claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, Company will reimburse the Member up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any applicable Copay.

C. Covered Services or Materials.

To be a Covered Service or Material (shown in the Schedule of Benefits), the Vision Examination or Materials must be furnished to a Covered Person (1) to check or improve his or her vision condition; (2) within the allowable frequency shown in the Schedule of Benefits; and (3) by an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider. In no event will coverage exceed the lesser of the actual cost incurred of the Covered Services or Materials or the limits of coverage shown in the Schedule of Benefits.

Section VI – Limitations and Exclusions

A. Limitations.

The Contact Lenses benefit is paid in lieu of benefits for Eyeglass Lenses, Eyeglass Frames. A Covered Person is only eligible to receive benefits under the Eyeglass Lenses benefit or the Eyeglass Frames benefit after the Contact Lenses Benefit Frequency has ended.

Benefits paid for Contact Lenses are paid only once during a Benefit Frequency and must be fully utilized at the time of purchase.

The Eyeglass Lenses benefit and the Eyeglass Frames benefit are paid in lieu of the Contact Lenses benefit, and a Covered Person is only eligible to receive benefits under the Contact Lenses benefit after the Eyeglass Lenses and Eyeglass Frames Benefit Frequency has ended.

B. Exclusions.

The items below are not Covered Services or Materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

(1) Eyeglass Frame cases;
(2) medical/surgical treatment of the eyes;
(3) replacement Eyeglass Frames and/or Eyeglass Lenses, except at normal intervals when covered services are otherwise available;
(4) bifocal lenses that are blended;

(5) Plano or non-prescription Eyeglass Lenses or sunglasses;
(6) cosmetic items;
(7) any lenses that are faceted, high-index or laminated.
(8) groove, drill or notch and roll and polish;
(9) two (2) pairs of eyeglasses, in lieu of bifocals, trifocals or progressive lenses.
(10) coating on Eyeglass Lenses (factory scratch coating, anti-reflective coating, sunglass colors, etc.);
(11) orthoptics, vision training and any associated supplemental testing;
(12) low (subnormal) vision aids or aniseikonic lenses;
(13) oversize lenses (any Eyeglass Lens with an eye size of 61mm or greater);
(14) any lenses that are polaroid, polished bevel, prism or slab-off;
(15) charges incurred after the Master Policy ends or the Member's coverage under the Master Policy ends, except as stated in the Master Policy;
(16) any eye examination or corrective eyewear required by an employer as a condition of employment;
(17) services and materials provided by another vision plan (except in the case of Coordination of Benefits);
(18) services for which benefits are paid by workers' compensation;
(19) benefits provided under the Member's medical insurance, except in the case of Coordination of Benefits;
(20) tints (including ultraviolet tint or coating (except pink tint #1 and #2); and
(21) additional cost for Contact Lenses or for an Eyeglass Frame over the allowance.

Section VII – Claims

A. In-Network Claims.

When a Member receives services from an In-Network Provider, the In-Network Provider will usually handle all claims and administrative services. In-Network Providers typically submit charges directly to the Administrator.

B. Out-of-Network Claims.

In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, the Member must submit a written Claim (also sometimes referred to as a proof of loss). The Claim must be sufficient to identify the Member, the name of the Group Sponsor and the Master Policy Number. Claim forms are available through the Administrator or the Member may submit itemized receipts for services.

C. Notice of Claim; Claim Forms; Proof of Loss.

Written notice of Claim must be given within twenty (20) days after a covered loss starts. Such notice can be given to Company at PO Box 967, Rancho Cordova, CA 95741 or such other address designated in writing by the Company. This notice should include the Member's name and the Master Policy Number. Failure to provide written notice within the twenty (20) day period will not invalidate or reduce a Claim if it can be shown that it was not reasonably possible to give notice within twenty (20) days and notice was given as soon as reasonably possible.

Upon Company's receipt of a notice of Claim from a Member (or other person making a Claim) in connection with Covered Services or Materials provided by an Out-of-Network Provider (or by an In-Network Provider if the In-Network Provider fails to file a Claim), Company will send the Member (or person making the claim) such forms as are usually furnished by it for filing proof of loss. If the forms are not sent to the Member (or person making the claim) within fifteen (15) days after the Company receives notice of any Claim, the Member (or person making the Claim) shall be deemed to have complied with the requirements of this Member Certificate as to proof of loss upon submitting, within the time fixed in this Member Certificate for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which Claim is made.

A written proof of loss must be given to the Administrator in case of a Claim for loss for which Company provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which Company is liable, and in case of a Claim for any other loss, within ninety (90) days after the date of such loss. Company will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof of loss must be given to the Administrator as soon as reasonably possible and in no event later than one (1) year after it is due, unless the Member is legally incapable of doing so. If the Member is legally incapable of submitting such proof, the Member may submit proof of loss at any time that is reasonably possible for the Member to do so.

D. Payment and Timing of Claims.

Benefits payable under this Member Certificate will be paid to the Member within thirty (30) days following Company's receipt of written proof of loss. Any balance remaining unpaid at the end of Company's liability will be paid immediately upon receipt of written proof of loss. Except as otherwise set forth herein, all benefits will be payable to Member unless assigned by Member or by operation of law. Any accrued benefits unpaid at the time of a Member's death will be paid to that Member's estate. If Member utilizes a public hospital or clinic, and such hospital or clinic submits a Claim, whether or not Member has made an assignment of benefits, Company will pay the benefits provided by this Policy directly to such hospital or clinic. If, however, a Claim provided by this Policy is paid and then such public hospital or clinic files a Claim, Company will not be liable for the duplicate payment of such benefits to such hospital or clinic.

E. Grievance Procedure; Review Procedure.

If a Claim is wholly or partially denied, Company will notify Member in writing of such denial and of Member's right to file a grievance and the procedure to follow. The written notice will state the specific reason for the denial of benefits. Within one hundred eighty (180) days of receipt of such written notice, a Member may file a grievance and make a written request for review to:

Superior Vision Services, Inc.
Attention: Appeal Review
P.O. Box 967
Latham, NY 12110

Company will acknowledge receipt of a grievance in writing within ten (10) working days and will investigate the matter within twenty (20) working days after receipt of the grievance. If additional time is needed to complete the investigation, Company will notify the Member in writing on or before the twentieth (20^{th}) working day. The investigation will be completed within thirty (30) working days

thereafter. Company will notify the Member in writing of the decision within five (5) working days following the investigation.

Member or someone on his or her behalf has the right to appear in person before Company's grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. To do so, Member must notify Company in writing. Company will inform Member in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this grievance procedure, a grievance is a written complaint submitted in accordance with the above procedure by a Member or by a representative of Member regarding dissatisfaction with the administration of claims practices or the provision of services relative to the Member.

A Member has the right to file an appeal with the Director of the Missouri Department of Insurance at any time. For detailed information on filing an appeal with the Missouri Department of Insurance, (MDI), contact: Missouri Department of Commerce and Insurance, ATTN: Consumer Affairs, PO Box 690, Jefferson City, MO 65102. The consumer hot line is 1-800-726-7390.

F. Prohibited Referrals.

Company reserves the right to seek repayment from a health care practitioner, including a Health Care Practitioner, or a Covered Person, as applicable, of any amount paid for a Claim, bill or other demand or request for payment Health Care Services that the appropriate regulatory board determines were provided as a result of a Prohibited Referral.

G. Extension of Benefits.

Termination of coverage under the Master Policy will be without prejudice to any Claim for continuous loss that commenced while coverage under the Master Policy was in force. However, the payment of benefits after the termination date will be predicated upon continuing loss for which benefits were payable prior to such termination date and limited to a course of treatment for at least ninety (90) days after the date coverage terminates or the payment of the maximum benefits payable for such loss, whichever comes first.

If a Member ordered eyeglasses or Contact Lenses while coverage under the Master Policy was in force, Company will continue to provide covered benefits in accordance with the Master Policy at the time coverage terminates for any eyeglasses or Contact Lenses received within thirty (30) days after the date of the order.

Section VIII – Coordination of Benefits (COB)

When a Member has vision coverage under more than one Plan, the benefits payable between the Plans will be coordinated so that the total payment under all Plans is no more than 100% of the Member's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of Coordination of Benefits.

If a Member's benefits paid under the Master Policy are reduced due to Coordination of Benefits, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

A. Order of Benefit Determination.

When the Master Policy is the Primary Plan, Company will pay benefits as if there were no other Plans, and when a person is covered by a Plan without a Coordination of Benefits provision, the Plan without the provision will be the Primary Plan.

When a person is covered by more than one Plan with a Coordination of Benefits provision, the order of benefit payment will be as described below.

(1) **Non-Dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

(2) **Dependent Child/Parents Not Separated or Divorced.** For a dependent Child, the Plan of the parent whose birthday occurs first in the calendar year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent Child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, Company will also use that basis.

(3) **Dependent Child/Separated or Divorced Parents.** If two (2) or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the Child are determined in the following order:

(a) the Plan of the parent who has responsibility for providing coverage as determined by a court order;

(b) the Plan of the parent with custody of the Child;

(c) the Plan of the spouse of the parent with custody; and

(d) the Plan of the parent without custody of the Child.

(4) **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the Child's medical expenses, the rules as shown for dependent Child/parents not separated or divorced shall apply.

(5) **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(6) **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

B. Right to Make Payments to Another Plan.

Coordination of Benefits may result in payments made by another Plan that should have been made by Company, and thus Company has the right to pay such other Plan all amounts it paid which would

otherwise have been paid by Company. Company will be discharged from liability to the extent of such payments, the amounts of which will be treated as benefits paid under the Master Policy.

C. Right to Receive and Release Needed Information; Right to Recovery.

Company may release to, or obtain from, any other insurance company, organization or person information necessary for Coordination of Benefits without being required to obtain the consent of, or provide notice to, the Member or any claimant. The Member is required to give Company information necessary for Coordination of Benefits.

If Coordination of Benefits results in overpayments by Company, then Company has the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made; provided, however, that with respect to a claim subject to Mo. Rev. Stat. 376.384.1(3), the Company may not request a refund or offset against a claim more than twelve months after the Company has paid the claim except in cases of fraud or misrepresentation by the health care provider.

Section IX – Termination of Coverage; Master Policy Cancellation

Coverage for a Member and all Covered Dependents terminates on the earliest of the following dates: (1) the date the Master Policy terminates; (2) the date the Group Sponsor's coverage terminates under the Master Policy; (3) the last day of the month in which the Member is no longer an eligible Member; (4) the date the Member dies; and (5) on any Premium Due Date, if full payment for coverage is not made within thirty-one (31) days following the Premium Due Date, subject to the Grace Period provision.

Coverage for each Covered Dependent terminates on the earliest of the date he or she is no longer an Eligible Dependent, and the date Company receives a Member's request to terminate Covered dependent coverage.

Company may cancel the Master Policy at any time by providing at least 60 days prior written notice to the Group Sponsor or as otherwise permitted in the Master Policy. The Group Sponsor may cancel the Master Policy at any time by providing at least 31 days advance written notice to Company or as otherwise permitted in the Master Policy. Upon any cancellation, Company shall promptly return on a prorated basis any unearned premium paid as required by law. The Group Sponsor shall promptly pay any unpaid prorated earned premium. Such cancellation shall be without prejudice to any Claim originating prior to the effective date of such cancellation.

Section X – Legal Action

No legal action may be brought to recover on the Master Policy prior to sixty (60) days after written proof of loss has been furnished as required by the Master Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

Section XI –Replacement of Existing Coverage

When the Master Policy replaces coverage the Group Sponsor previously obtained through another plan or policy (the "Prior Plan"), coverage under the Master Policy will not be considered as replacement

coverage unless the Group Sponsor's coverage under the Master Policy takes effect within sixty (60) days following termination of coverage under the Prior Plan.

A Member who was covered by the Prior Plan at the date of discontinuance, but who might not qualify for coverage under this Master Policy because the person is not actively at work or is confined in a hospital, will be covered under the Master Policy if (1) the person was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision on the date the Group Sponsor's coverage with the Prior Plan terminated; (2) the Prior Plan covered more than 25 people; and (3) the person is a Member of an Eligible Class under the Master Policy. The benefits payable for such a Member will be the benefits of the Master Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.

Section XII - Group Information Schedule

Member:	**REFER TO IDENTIFICATION CARD**
Certificate Number:	**REFER TO IDENTIFICATION CARD**
Group Sponsor:	**Archdiocese Of St Louis**
Group ID:	**20070020**
Effective Date:	**July 1, 2020**
Renewal Date:	**July 1, 2025**
Initial Term:	**sixty (60) months**
Eligible Classes:	**Full Time employees working one thousand (1,000) hours per year**
Waiting Period:	**As assigned by Group Sponsor**
Mode of Premium Payment:	**MONTHLY**
Method of Premium Payment:	**Remitted by Group Sponsor to Company**
Premium Due Date:	**within 15 days of invoice date**

Section XIII - Schedule of Benefits

Dynamic Select Plus 150

COVERAGE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS*	BENEFIT FREQUENCY
EXAMS			
Comprehensive Spectacle Eye Examination **with Dilation**	**Covered in full after $10.00 Copay**	**$40 allowance** (less $10.00 Copay)	Once Every 12 Months
Contact Lens Fit	**$40 allowance**	In-network benefit only	Once Every 12 Months
MATERIALS			
Materials Copay Applies to Standard Lenses and Frames, or Contact Lenses.	**$25.00 Copay**	**$25.00 Copay**	*See below*
Eyeglass Lenses** **(CR-39 standard plastic)**	**Standard Lenses:** - Single - Bifocal - Trifocal - Lenticular **Covered in full** after Copay	**Standard Lenses:** - Single: **$20 allowance** - Bifocal **$40 allowance** - Trifocal **$60 allowance** - Lenticular **$100 allowance** (less applicable Copay)	Once Every 12 Months
Eyeglass Frames	Covered in full after Copay on *Special Frame Selection** **$150 allowance** outside of the selection (less applicable Copay)	**$60 allowance** (less applicable Copay)	Once Every 24 Months
Contact Lenses** **Elective (in lieu of Eyeglasses and Medically Necessary Contact Lenses)**	**$150 allowance** (less applicable Copay)	**$90 allowance** (less applicable Copay)	Once Every 12 Months
Contact Lenses** **Medically Necessary (in lieu of Eyeglasses and Elective Contact Lenses)**	**$250 allowance** (less applicable Copay)	**$250 allowance** (less applicable Copay)	Once Every 12 Months
Lens Options **When purchased with standard lenses or frames. Additional Copays apply as listed**	**Standard Polycarbonate Lenses, $0 Copay** for Covered Persons age 19 and younger	In-network benefit only	Once Every 12 Months
	Standard Progressive Lenses: **$50 Copay**	In-network benefit only	Once Every 12 Months
	Photochromic Lenses: **$60 Copay**	In-network benefit only	Once Every 12 Months
DISCOUNTS			
Eyeglass Lenses Upgrades	**Member Cost: Discount Pricing** Ultra Violet Coating Premium Scratch Coating Anti-Reflective Coating Standard Polycarbonate Polarized Lenses Tinting (Solid or Gradient) Additional Frames and Lenses Sunwear and Other Accessories	In-network benefit only	Unlimited use
Laser Vision Correction **(LASIK)**	Member Cost: Discount Pricing	In-network benefit only	N/A

- Where an “allowance” is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.
- Where “Member Cost: Discount Pricing” is shown above, the Member is responsible for paying for such items, and there may be discount pricing available when received from certain In-Network Providers. Members contact Superior Vision for more information regarding the discounted pricing available from In-Network Providers.

* Submit Member Reimbursement Request Form and an itemized paid receipt to Company.

** Subject to the additional limitations set forth in Section VI.A of the Member Certificate, only one of these benefits will be paid once during the Group’s Benefit Frequency and must be fully utilized at the time of purchase.

***A frame selected from a sampling of frames designated by the In-Network Provider that, when purchased with Standard Lenses, is covered in full except for the applicable Copay.

DeltaVision®

Advantica Insurance Company
Delta Dental of Missouri
Superior Vision Services, Inc.

Joint Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Advantica Insurance Company, Delta Dental of Missouri, and Superior Vision Services, Inc. are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

You have a Right to:

Get a copy of health and claims records

- You may request a copy of your health and claims records, which we will provide to you.
- We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You may request a correction to your health and claims records
- We may say "no" to your request, but we'll tell you why in writing.

Request confidential communications

- You may request us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if disclosing the information could endanger you.

Ask us to limit what we use or share

- You may request us to limit the use of or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request and may say "no" if it would affect your care.

Get a copy of this privacy notice

- You may request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will verify that the person has this authority to serve as your personal representative prior to providing any action.

Get a list of those with whom we've shared information

- You may request a list (accounting) of who we've shared your health information for six years prior to the date you ask.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one free accounting a year but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting:
  Superior Vision Services
  Privacy Office
  PO Box 1416
  Latham, NY 12110
  1-800-571-3366
  Privacy@superiorvision.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you have a right on to tell us how to share your information in the situations described below. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care;
- Share information in a disaster relief situation

If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission for marketing purposes – except that we may use your health information for marketing for limited situations as allowed by law. ***Example:*** *We may inform you about health-related products or services or sale of your information*

Our Uses and Disclosures

We typically use or share your health information to:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you. ***Example*****:** *We may tell your provider information about your prior treatments so he or she can provide appropriate services for you.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary. ***Example:*** *We use health information about you for underwriting, premium rating, quality control and improvement activities.*
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Pay for your health services

- We can use and disclose your health information as we pay for your health services***. Example:*** *We share information about you with another plan that covers you to coordinate payment for your treatment.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration. ***Example:*** *Your company contracts with us to provide a health plan and we provide your*

company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. Before we share your information we must comply with the law.
- For more information: www.hhs.gov/ocr/privacy/HIPAA/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share your health information in response to a court or administrative order or in response to a subpoena.
- Response to Inquiries
- We may discuss PHI with your spouse or parent of a dependent child if such individual contacts us for assistance with eligibility, coverage, or payment issues; however, you have the right to request that we do not discuss your PHI with these individuals for this purpose.

Business Associates

- We may share your health information with certain individuals and companies that we contract with to perform functions for us. We require these individuals and companies to protect your information and keep it confidential. ***Example:*** *We may share information with a printing company to print your explanation of benefits.*

Stop-Loss Insurance

- If you are covered under a group plan, we may share your health information with your employer's stop-loss carrier to pay claims or rate premiums.

Your Employer

- We will not share information with your employer for purposes of obtaining family medical leave coverage or for job related activities, such as promotion or firing, without your written permission.

State Law

- When your state's laws have stricter requirements for privacy or security of your PHI than federal law, we will follow state law. ***Example:*** Missouri *law requires that we get your written permission before we share particularly sensitive information such as HIV/AIDS status.*

Our Responsibilities

- We are required by law to maintain the privacy and security of your PHI.
- We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information other than as described in this notice without first obtaining your written authorization. You may revoke your authorization in writing any time; however, your revocation will not be effective for actions already taken in reliance of the authorization.

For more information see: www.hhs.gov/ocr/privacy/HIPAA/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We are required to maintain the privacy of your PHI and to abide by the terms of this notice as currently in effect. If our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all health information that we maintain. If this notice is revised, we will post the revised notice on www.superiorvision.com/legal. If there is a material change, we will send a copy to the current address we have on file.

Download this Notice - This notice is available online at https://www.deltavisionmo.com/PrivacyHIPAA
Effective Date - This notice is effective May 1, 2020.

SVPN-DVMO-052020