Essential Vision Plan

CERTIFICATE OF COVERAGE

Underwritten by the WEA Insurance Corporation

45 Nob Hill Road (53713-3959)
P.O. Box 7338 (53707-7338)
Madison, Wisconsin

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IC OGC 4072-1116

Important Notices

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE—If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

WEA Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338
Voice/TTY: (800) 279-4000 or (608) 276-4000

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

You may view all of the WEA Insurance Corporation insurance policies on our website, weatrust.com. If we amend your Certificate, we add the amendment to our online plan documents. If you prefer to receive a paper Certificate, please call our Administrator, at the number identified on the following page.

WEA Trust Essential Vision Plan

This is a preferred provider group vision insurance plan. This document is a description of group vision insurance benefits. If you are a covered employee, then this Certificate entitles you to reimbursement of the covered vision care costs incurred by you and your covered dependents, subject to the reimbursement limits defined in the Certificate and your Benefit Summary.

We do not cover all vision care services. We reimburse only for those services that are explicitly defined in this Certificate.

Your choice of provider (Network or Non-Network Provider) determines how much we will reimburse for covered services and, consequently, how much you must pay for your vision care.

The eligibility criteria for coverage described in this Certificate may be changed by one or more of the Optional Eligibility Provisions that are located in the Appendix at the back of this document. The Benefit Summary indicates which Optional Eligibility Provisions, if any, apply to your coverage.

If you have any questions about the benefits or requirements of this Certificate, contact the Administrator:

National Vision Administrators, L.L.C. (NVA)
P.O. Box 2187
Clifton, NJ 07015
(877) 262-7915

IC OGC 4072-1116

Table of Contents

Section 1
General Provisions

General Information About This Plan
This is a preferred provider group vision insurance plan. In accordance with its terms, we will reimburse for covered vision care services incurred by covered employees and their covered dependents, subject to the applicable copayment amounts, fixed fees, retail allowances and frequency limits defined in Section 4 of the Certificate.

This Certificate does not provide reimbursement for all vision care services. We will reimburse only for those services explicitly defined in, and not limited or excluded by, the provisions of this Certificate.

Our reimbursement for covered services and how much you must pay for your vision care is determined by your choice of Network or Non-Network Provider.

If you have any questions about the benefits or requirements of this Certificate, call our Administrator at (877) 262-7915.

Premiums
The premiums are paid by the employer and their insured employees. You may be required to contribute, either in whole or in part, to the cost of insurance. This is subject to the terms established by your employer. All employee contributions are determined on a non-discriminatory basis.

Benefit Changes or Plan Termination
The employer may change or terminate the plan at any time. Any changes to the plan will be communicated immediately by the employer to the individuals covered under the plan.

Statements by Our Employees or Agents
No statement or representation by any of our employees or agents can alter or waive any requirement or provision of this Certificate. No statement or representation relating to the interpretation or application of any provision of this Certificate will be binding unless an officer of our company issues it in writing.

Under no circumstances will the employer be deemed our agent without our written authorization.

Entire Contract and Changes
The entire contract of insurance consists of:

1. This Certificate and any Optional Eligibility Provisions.

2. The Benefit Summary.

3. The Group Vision Insurance Agreement (Agreement) between the employer and us.

4. The employer's application form.

5. The employees' enrollment forms.

If there is a conflict between the contract and any summaries provided to you by your employer, the contract will control.

No change in this Certificate will be valid unless written and signed by an officer of our company.

If any Certificate provision is changed while coverage is in force, the change will apply only to those covered services that are received after the effective date of the change.

Conformity With State Statutes

Any provision of this Certificate that conflicts with the applicable statutes of Wisconsin, or with any applicable federal law, is hereby revised to conform to the minimum requirements of those statutes. The effective date of any such required revision will be the latest date permitted by those statutes.

Section 2
Definitions That Apply to All Provisions

The terms defined below appear throughout this Certificate. When these terms are capitalized in the text of the Certificate, they have the meaning that is defined below.

Administrator means the entity which services the plan as agreed to in a contract with us.

Contact Lenses, Elective – These are contact lenses an individual chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective –These are contact lenses that are prescribed solely for the purpose of correcting a specific medical condition. These lenses allow an individual to achieve a specified level of visual acuity that would not be possible using conventional eyeglasses.

Eyeglass Lenses refer to a standard glass or plastic (CR39) lens, which is optically clear. Standard multifocal 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.

Materials mean corrective Eyeglass Lenses, frames and Contact Lenses.

Network Provider means an Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide the covered services for a contracted rate. These providers are listed in the Network Provider Directory. You will generally incur less out-of-pocket costs for services from a Network Provider.

Non-Network Provider means an Ophthalmologist, Optometrist or Optician who is not a Network Provider. These providers have not entered into an agreement with the Administrator to limit their charges. You will generally incur more out-of-pocket costs for services from Non-Network Providers.

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 Ophthalmologist cannot be 1) the covered individual or his or her covered dependent; or 2) retained by the employer.

Optician means a person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the covered individual or his or her covered dependent; or 2) retained by the employer. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in

which services are rendered. The Optometrist cannot be 1) the covered individual or his or her covered dependent; or 2) retained by the employer.

Note: In addition to the above capitalized terms, the following definitions also apply:

- Any time the word **"services"** appears in this Certificate, it refers to any vision care professional service or correction Materials.

- Any time the words **"we," "us,"** and **"our"** appear in this Certificate, they refer to the WEA Insurance Corporation. To the extent that our Administrator performs certain services, **"we," "us,"** and **"our,"** may also refer to our Administrator.

- Any time the words **"you"** or **"your"** appear in this Certificate, they refer to any individual who is covered by the Certificate. The exception to this is in Section 3, "Eligibility and Coverage of Employees and Their Dependents" where "you" and "your" refer only to the employee of the employer who purchased this group vision insurance plan.

- Any time the word **"covered"** appears in the benefit provisions of this Certificate, it refers to services that are reimbursable. Reimbursement is subject to applicable copayment amounts, fixed fees, retail allowances, and frequency limits. See Section 4 for a discussion of these concepts.

Section 3
Eligibility and Coverage of Employees and Their Dependents

This section describes the individuals who are eligible for coverage under this Certificate. It explains when those individuals become eligible for coverage, when their coverage begins, and when coverage ends.

The date you become eligible for coverage is subject to any applicable waiting period. The waiting period is the length of time you must be continually at work for your employer before you are eligible for coverage under this Certificate. The waiting period, if any, is established by your employer and is specified in the Agreement between your employer and us.

Note: Whenever the terms "you" or "your" appear in this section, they refer only to an employee of the employer who purchased this group vision insurance plan. Whenever the term "class of eligible employees" is used, it refers to the occupational group(s) of employees specified by the employer as being eligible for coverage as part of an insured group.

How to Obtain Coverage

In order to obtain coverage you must provide an enrollment form to us, listing all individuals for whom you wish coverage, within 30 days of the date you become eligible. This 30-day period is an initial enrollment period during which you and your dependents will be enrolled if eligible. If we receive your enrollment form after the 30-day period, the "Rules for Late Enrollments" will apply.

Once enrolled, you and your dependents must remain enrolled for a minimum of twelve (12) months if you and your dependents otherwise remain eligible for coverage under the Certificate. Once you and your eligible dependents have been enrolled for at least twelve (12) months, you may voluntarily disenroll yourself and/or your dependents, but you may only do so during your employer's annual open enrollment period. If you and/or your dependents voluntarily disenroll from the plan, coverage will terminate on the effective date specified by your employer for the annual open enrollment period. The "Rules for Late Enrollments" will apply if you and/or your eligible dependents choose to later re-enroll.

Eligibility and When Coverage Begins

Current Active Employees

You are eligible for coverage on the date this plan takes effect for your employer only if **both** of the following apply:

- You are engaged in the active performance of your regular job duties on that date. To determine eligibility for coverage, you are considered engaged in the active performance of

your regular job duties each day of a regular paid vacation, any regular nonworking day or holiday, or if you are not working due to your own illness, medical condition, or disability as determined by your employer.

- You belong to the class of eligible employees specified by your employer on the Agreement.

Your coverage will begin on the date this plan takes effect for your employer if we receive your enrollment form within 30 days of that date.

New Employees

If you belong to the class of eligible employees specified by your employer on the Agreement, you are eligible for coverage on the later of the following dates:

- The date you complete any waiting period specified by your employer.

- The date you begin the active performance of your regular job duties. You are considered engaged in the active performance of your regular job duties each day of a regular paid vacation, any regular nonworking day or holiday, or if you are not working due to your own illness, medical condition, or disability as determined by your employer.

Your coverage will begin on the date you become eligible if we receive your enrollment form within 30 days of that date.

Your Dependents

If you are covered by this Certificate, the following dependents are eligible for coverage:

1. Your legal spouse.

2. Your biological child, legally adopted child, stepchild, or legal ward* who is under the age of 26.

   ***Note:** To be initially eligible for coverage, your legal ward must be under the age of 18 or must be a ward who was covered by the previous employer-sponsored group plan with routine vision coverage that this plan replaced. In addition, you must have sole and permanent guardianship of both the individual and the individual's estate.

3. Your biological child, legally adopted child, stepchild, or legal ward of any age who is a full-time student **and** meets **both** of the following requirements:

   - Was initially called to federal active duty for the National Guard or a reserve unit of the United States armed forces before age 27, while attending an institution of higher education as a full-time student.

   - Within 12 months of the date of fulfilling his or her active duty obligation, applied to an institution of higher education as a full-time student.

4. A biological child of your covered dependent child or legal ward (i.e., your grandchild), but only until your child or legal ward becomes 18 years old or marries, whichever occurs first.

Your dependents are eligible for coverage on the date your coverage takes effect. Their coverage will begin on the date your coverage takes effect if we have received your application for their coverage within the first 30 days of their eligibility.

Children Who Become Re-eligible for Coverage—If your covered dependent child becomes ineligible for coverage because he or she no longer meets the criteria to qualify as an eligible dependent, that child will lose coverage under this Certificate. However, the child may once more become eligible if the criteria are again met. If this happens, we must receive the application for your dependent child's coverage within 30 days of the event that gave rise to that dependent's re-eligibility. Coverage for that child will resume on the first of the month following the event that gave rise to the re-eligibility if you notify us promptly of the child's re-eligible status. If we do not receive the application within the 30-day time limit, your dependent child will be subject to the "Rules for Late Enrollments" described later in this section.

Note: If you have **single** coverage and want to add a dependent child who becomes re-eligible, you must change to family coverage. We must receive the application for your dependent child's coverage within 30 days of the event that gave rise to that dependent's re-eligibility. If we do not receive the application within the 30-day time limit, your dependent child will be subject to the "Rules for Late Enrollments" described later in this section.

Adding Dependents Through Marriage—If you marry, you may obtain coverage for any new eligible dependents and you may change from single to family coverage if we receive the required enrollment form within 30 days after the date of your marriage. In this case, coverage for these new dependents begins on the date of your marriage. If we receive your application for their coverage after the 30-day period, their enrollment will be subject to the "Rules for Late Enrollments" described later in this section.

Newborn Child—A newborn's coverage begins at birth if you have family coverage. If you have single coverage, you must notify us of the birth and your desire to obtain family coverage within 60 days of the birth date. If we are not notified and the required premiums are not paid within 60 days of the birth date, we may refuse coverage for the newborn unless, within one year of the birth date, we receive all required premiums, plus interest as permitted by law, from the date of birth. If we do not receive the required premiums within one year of the birth date, you will be able to obtain coverage for the child only through the "Rules for Late Enrollments" described later in this section.

Newly Adopted Child—A newly adopted child is eligible for coverage on the earlier of these dates:

- The date that a court makes a final order granting adoption.

- The date that the child is legally placed with you for adoption.

Coverage for the adopted child will begin on the date he or she first becomes eligible if we receive your application for the child's coverage, or written notification of the adoption, within 60 days after that date. If we do not receive an application for the child's coverage within 60 days after he or she becomes eligible, you will be able to obtain coverage for the child only through the "Rules for Late Enrollments" described later in this section.

Legal Wards—A legal ward is eligible for coverage on the date established by the court order as the date on which you began guardianship. Coverage for your legal ward will begin on the date he or she became eligible if **both** of the following apply:

- You have family coverage.

- We receive your application for your legal ward's enrollment within 30 days after he or she first became eligible for coverage.

Your Duty to Provide Information

If you are covered by this Certificate, you must provide the information we need to accurately determine whether your dependents are eligible for coverage and to pay benefits. Examples include but are not limited to:

- **You must let us know when one of your covered dependents is no longer eligible for coverage and upon our request, you must provide us with evidence of eligibility for your dependents.** When we enroll your dependents, we accept your representation of their eligibility. You must notify us when a covered dependent is no longer eligible. You must also provide us with evidence of eligibility for your dependents, upon our request. Your failure to provide such evidence, upon request, is considered evidence of fraud and material misrepresentation. If you do not provide the requested evidence of eligibility, we have the right to terminate coverage for the dependent. The termination may be retroactive to the date the dependent became ineligible for coverage under the plan.

- **You, or your provider, must provide, at your own expense, the patient record documentation we need to determine if services are covered.** We will tell you what we need to make a determination.

If you fail to timely provide us with the information required to determine eligibility for coverage and to pay benefits, and we pay claims in error as a result, we have the right to recover the overpayment. You will be responsible for the cost of any claims paid in error, together with all costs and legal fees we incur in recovering those claims payments. See also "Our Right of Review and Recoupment" in Section 7.

Continuing Coverage for Eligible Employees Absent From Work

Your employer may continue your coverage if you are absent from work because of your own illness, medical condition, or disability if **both** of the following conditions apply:

- Your employer considers you to be an employee.

- Your employer is acting on a basis which does not discriminate for or against any eligible employee.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The date this plan terminates for your employer for any reason.

- The end of the period for which the last premium was paid for you. **Note**: Once you have been enrolled for at least twelve (12) months, you may voluntarily disenroll yourself, but you may only do so during your employer's annual open enrollment period. Coverage will terminate on the effective date specified by your employer for the annual open enrollment period.

- The last day of the month in which you enter the military forces of any state or country, including the United States, or the last day of the month after you have served on active duty as a member of a reserve unit of the armed forces for at least 30 consecutive days.

- The last day of the month in which you cease to be a member of the class of eligible employees specified by your employer on the Agreement for coverage under this plan. For example, you have a change in your job duties or in the number of hours worked that renders you ineligible for coverage.

- The last day of the month in which your occupational group ceases to be part of the class of eligible employees specified by your employer on the Agreement as being part of an insured group.

- The last day of the month in which you become ineligible because of the termination of your employment, whether voluntary or involuntary.

- The date on which you fail to comply with any provision of this Certificate.

- The date of your death.

Coverage for any dependent will end on the earliest of the following dates:

- The date this plan terminates for your employer for any reason.

- The end of the period for which the last premium was paid for your dependent. **Note**: Once your dependents have been enrolled for at least twelve (12) months, you may voluntarily disenroll them, but you may only do so during your employer's annual open enrollment period. Coverage will terminate on the effective date specified by your employer for the annual open enrollment period.

- The last day of the month of the divorce or annulment of your marriage is the date that coverage terminates for your spouse.

- The last day of the month in which your dependent enters the military forces of any state or country, including the United States, or the last day of the month after your dependent has served on active duty as a member of a reserve unit of the armed forces for at least 30 consecutive days.

- The last day of the month in which your dependent child no longer meets the criteria to be covered as your dependent under your coverage.

- The date of your dependent's death.

- The date your coverage ends for any reason, except for your death. If you die, coverage for your dependents will end on the last day of the month of your death.

Rules for Late Enrollments

Late Enrollment

It is important that you apply for coverage by submitting an enrollment form, listing all individuals for whom you wish coverage, within 30 days of becoming eligible. If you waive or decline coverage when you are initially eligible, you will not be eligible to enroll until your employer's next annual open enrollment period

Annual Open Enrollment

Your employer will provide an annual open enrollment period during which you and/or your eligible dependents may enroll.

Your coverage will begin on the effective date specified by your employer for the annual open enrollment period, but only if **both** of the following apply:

- You complete an enrollment form, listing all individuals for whom you wish coverage.

- We receive your completed enrollment form within the annual open enrollment period specified by your employer.

If you do not meet these criteria, then you and/or your eligible dependents will have to wait until your employer's next annual open enrollment period to enroll.

Special Late Enrollment Circumstances

If you are an active member of the class of eligible employees and have completed any waiting period required by your employer, you may enroll yourself and your eligible dependents if you acquire an eligible dependent through marriage, birth of a child, or adoption or placement for adoption of a child.

We must receive an enrollment form from you, listing all individuals for whom you wish coverage, within 30 days of the date you experience the special late enrollment circumstance. If we do, coverage for your eligible dependents will begin on the date you experience the special late enrollment circumstance. If we receive the enrollment form for your eligible dependents

after the 30-day period, it will not be accepted and your eligible dependents will only be eligible to enroll during your employer's annual open enrollment period.

Your Legal Rights to Continuation Coverage

In certain cases, you and/or your eligible dependents may be eligible to continue coverage under your employer's group vision plan in accordance with the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), if coverage is lost due to specific qualifying events. Continuation coverage is offered by the employer or the "COBRA administrator" designated by the employer to administer continuation coverage under COBRA. Please contact your employer or their "COBRA administrator" if you have questions related to federal continuation coverage, and/or eligibility for such coverage.

Section 4
General Provisions That Apply to All Benefits

This Certificate covers limited vision care services. This section details the criteria by which we determine whether your services are covered.

This section also explains the factors that affect the amount of reimbursement for covered services:

1. Your choice of vision care provider (Network or Non-Network Provider).
2. Copayments.
3. Fixed fees.
4. Retail allowances.
5. Frequency limits.

How We Determine if a Service Is Covered

Covered services are shown on your Benefit Summary. To be a covered service, the service must be provided:

1. By an Ophthalmologist, Optometrist, or Optician;
2. To check vision or improve a vision condition;
3. Within the frequency limits shown on your Benefit Summary.

We reimburse the lesser of the following amounts:

- The actual cost incurred for the service provided; or,
- The applicable benefit limits shown on your Benefit Summary.

Factors That Affect the Reimbursement Amount

Your Choice of Vision Care Provider (Network or Non-Network Providers)

Your choice of vision care provider determines how much we will reimburse for covered services and, consequently, how much you must pay for your vision care. You receive the most reimbursement your vision plan provides only when you obtain covered services from Network

Providers. The amount you must pay out-of-pocket for your vision care will be significantly more when you receive services from Non-Network Providers.

Network Providers—When covered services are received from a Network Provider, we will pay the Network Providers directly, based on the Network benefits shown in the Benefit Summary.

Non-Network Providers—If you receive services from a Non-Network Provider, you must pay the provider in full. You are responsible for sending us a claim. See Section 8, "Claim Procedures." We will reimburse you up to the retail allowance amounts shown on your Benefit Summary, subject to applicable frequency limits.

Provider Directory

You can access the directory of Network Providers online at our Administrator's website specified on your Benefit Summary. If you prefer, you can request a paper copy of a vision Network Provider Directory by calling our Administrator at (877) 262-7915.

Provider information changes occasionally. Therefore, we recommend you confirm that your chosen provider is in the Network prior to receiving care.

Identification Card

After you enroll, you will receive an insurance identification card with your subscriber number, which you will need to log in to our Administrator's website. If you choose, you may present this card each time you receive services from any provider, or you may seek routine vision care services from a Network Provider by simply letting them know that you have a WEA Trust vision plan administered by NVA.

Coding and Billing Standards

We rely on medical documentation to determine if procedure or billing codes for services reported and billed by a vision care provider are appropriate. If the documentation indicates another code is more appropriate, we have the right to base our reimbursement on the service(s) supported by the documentation. We also have the right to deny claims for services that are billed inconsistently with industry-accepted coding standards.

Copayments

Reimbursement for covered services may be subject to a copayment. A copayment is a fixed amount you must pay out-of-pocket each time you receive certain services. Copayments do not apply to all services, and the amount may vary for different services. Your Benefit Summary specifies copayments you must pay and the services to which they apply.

Fixed Fees

These amounts, which are specified on your Benefit Summary, are the fixed fees you will pay under this Certificate for certain covered lens options when provided by a Network Provider. We encourage you to check your Benefit Summary so you know the fixed fee you will be required to pay for these covered services. Lens options not listed on the Benefit Summary will be priced by the Network Provider at their reasonable and customary retail price, less the

discount percentage listed on your Benefit Summary. This plan does not reimburse for lens options provided by a Non-Network Provider.

Retail Allowances
This amount, which is specified on your Benefit Summary, is the maximum amount this Certificate will reimburse for certain services. We encourage you to check your Benefit Summary so you know which services are limited to a retail allowance and the retail allowance amount we will pay for these covered services.

Frequency Limits
The frequency limits determine how often you can receive reimbursement for certain covered services. We pay a benefit if you receive certain covered services within the applicable frequency limits while your coverage under this Certificate is in effect. Your Benefit Summary specifies the frequency limits that apply to certain covered services.

Certificate Changes
If any Certificate provision is changed while your coverage is in force, the change applies only to covered services that are received after the effective date of the change.

Noncompliance With Certificate Requirements
Our waiver of any requirement of this Certificate will not constitute a continuing waiver of such requirement. Our failure to insist on compliance with any Certificate provision will not function as a waiver or amendment of that provision.

Section 5
Limitations and Exclusions

Benefits are subject to the limitations and exclusions listed in this section. Other factors that affect or limit reimbursement for covered services are discussed under "Factors That Affect the Reimbursement Amount" in Section 4.

Limitations

The Certificate covers Contact Lenses for aniseikonia. It does not cover eyeglasses (frames and lenses) made for this condition.

Non-Elective Contact Lenses are covered only when prescribed for any of the following medical reasons:

- Aphakia (after cataract surgery).
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses.
- Anisometropia of 4.0 diopters or more.
- Keratoconus.

Dilation is included as part of a routine exam under the Vision Exam benefit **only** when professionally indicated.

Exclusions

We do not reimburse expenses for, or in connection with, the following:

1. Vision examination of your eyes and related structures, unless your Benefit Summary indicates that vision examination services are covered.
2. Services rendered by a provider other than ophthalmologists, optometrists, or opticians acting within the scope of their licensure.
3. Diagnosis of eye pathology, and medical and/or surgical treatment of the eye, eyes, or supporting structures.
4. Experimental or non-conventional treatment or device.
5. Services in connection with:
    - Plano (non-prescription) contact lenses or eyeglasses.

- Subnormal visual aids such as magnifiers or adaptive telephones.
- Orthoptics, vision training, developmental visions procedures, and any associated supplemental testing.

6. Two pair of eyeglasses in lieu of bifocals, trifocals, or progressives.
7. Lens options provided by Non-Network Providers.
8. An eye examination or corrective eyewear required by an employer as a condition of employment, and safety eyewear unless otherwise covered under the Certificate.
9. Services provided by another vision plan or covered under the employee's medical insurance.
10. Services which are payable under any worker's compensation act, similar law, or any public program other than Medicaid, whether or not you apply for or receive them. This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise.
11. Costs incurred while you are not covered by this Certificate, except that vision correction Materials ordered before your coverage under this Certificate ends will be covered if those Materials are dispensed to you within 31 days of that termination date.
12. Missed appointments.
13. Copying and providing medical or any other type of information in support of a claim.

Section 6
Covered Vision Services

This section describes covered benefits. Your Benefit Summary specifies the copayments, fixed fees, retail allowances, and frequency limits that apply to certain services.

Reminder: The "Definitions" (Section 2), "General Provisions" (Section 4), and the "Limitations and Exclusions" (Section 5) also govern the actual benefits in every case. Reimbursement for covered services is subject to the "Factors That Affect the Reimbursement Amount," also in Section 4.

Vision Examination
Please see your Benefit Summary to determine if your Certificate covers vision examinations.

If vision examinations are covered, this Certificate reimburses for one complete examination of your eyes and related structures within the frequency limit specified on your Benefit Summary. The examination, to evaluate a new or existing visual condition, must be performed by a licensed optometrist or ophthalmologist.

The examination may include a patient history, an internal ophthalmoscopic examination, biomicroscopy, tonometry, and a determination of refractive status, unless otherwise contraindicated. Determination of refractive status means the quantitative procedure that yields the refractive data needed to determine your best visual acuity with lenses and to prescribe lenses.

Vision Correction Materials
This Certificate covers frames and Eyeglass Lenses, or Contact Lenses, prescribed by a licensed ophthalmologist or licensed optometrist for vision correction. The Certificate covers all types of Contact Lenses such as hard, soft, gas permeable and disposable lenses.

We will cover each of the following within the frequency limits specified on your Benefit Summary:

- A retail allowance toward one pair of frames.

- A retail allowance toward two Eyeglass Lenses for frames or a supply of Contact Lenses, Elective or Non-Elective, as prescribed.

  Note: There is one exception. For the treatment of aphakia (after cataract surgery), a pair of prescription single vision or multifocal Eyeglass Lenses is covered in addition to Non-Elective Contact Lenses for this condition.

The following necessary professional services are covered, but are reimbursed as part of the retail allowance for the applicable covered vision correction Material:

- Prescribing and/or ordering proper lenses.
- Assisting in the selection of a frame.
- Verifying the accuracy of the lens(es).
- Proper fitting and adjustment of eyeglasses.
- Fitting and follow up services associated with Contact Lenses (if Contact Lenses are provided as part of the coverage), up to your release from care.

Section 7
Claim Procedures

To receive reimbursement, you must send us within 90 days a written claim and proof that you have incurred a covered loss. Wisconsin law extends this period to 12 months beyond the 90 days required by this Certificate, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit.

Claim for Vision Care Services

We are happy to accept Network Provider-submitted claims that meet industry-accepted standards, and this will fulfill your obligation if the claim contains all the information we need to evaluate it.

If you receive services from a Non-Network Provider, you must pay the entire cost of services received at the time of service. You must submit claims for services from Non-Network Providers that satisfy our requirement to prove that you have incurred a covered loss. You can request a claim form from our Administrator by visiting the website specified on your Benefit Summary. We will then reimburse you for any covered services.

We rely on documentation from your patient record to determine if procedure or billing codes for services reported and billed by a vision care provider are appropriate. If the documentation indicates another code is more appropriate, we have the right to base our reimbursement on the service(s) supported by the documentation. We also have the right to deny charges for services that are billed inconsistently with industry-accepted coding standards.

Proof of Loss

You must provide both satisfactory proof that you have incurred a covered loss and the information that we need to calculate your benefits. In many cases, your claim form provides that proof. In other cases, we require additional documentation that any services you received fulfill our criteria for coverage. Whenever we have questions about whether a claim meets our criteria for coverage and whether reimbursement limits apply, we rely on objective, contemporaneous documentation from your patient's record and the advice of our medical consultants. You are responsible for obtaining and providing this information.

Some providers charge for copying and/or submitting documentation from your patient record. We do not pay or reimburse any fees charged for providing information, so you must pay any costs incurred.

How and When Claims Will Be Paid

We pay benefits within 30 days after we receive a claim and the required proof of loss. We reimburse the Network vision care providers from whom you received the services. You must pay for covered services rendered by Non-Network Providers, and we in turn will pay you.

If a benefit is payable to your estate or to a beneficiary not competent to give a valid release, we may pay the benefit to whomever we consider to be legally entitled.

Our Right of Review and Recoupment

We review claims both before and after payment. Whenever we find that any information is fraudulent, misleading, inaccurate, or incomplete, we have the right to reevaluate and retroactively modify our claim payment. We have this right regardless of whether we have paid some or all of the claim.

If we pay benefits that exceed those you're entitled to, you must repay the excess as soon as we notify you of the overpayment. We may, at our option, recover some or all of the overpayment by reducing subsequent benefits payable or by applying premium refunds due you. We have the right to charge reasonable interest on the delinquent amount.

Section 8
Your Right to a Resolution of Complaints

You have the right to a full and fair review of any complaints you may have about your claims or our administration of this Certificate. This section explains the rights you have under this Certificate and by law to receive explanations of what your plan covers and our decisions concerning your claims. It also explains your rights to seek resolution of complaints and adverse determinations.

Right to Information and Explanation

If you have questions about your benefits under this Certificate, how to receive maximum reimbursement for your routine vision care services, or if you have a complaint about our benefit determination, you may call and talk with one of our Administrator's customer service representatives at (877) 262-7915.

Right to an Investigation of Any Complaint

Most questions about benefits and claims payments can be resolved on an informal basis. Therefore, if you are dissatisfied after you have raised your question or complaint with our Administrator's customer service representative, we encourage you to call our dispute resolution specialist at (800) 279-4000 or (608) 276-4000 (Voice/TTY). Our dispute resolution specialist will promptly investigate your complaint and keep you informed about the progress of the investigation.

Right to File a Complaint With the Office of the Commissioner of Insurance

You have the right to file a complaint with the **Office of the Commissioner of Insurance**, a state agency that enforces Wisconsin's insurance laws. You can contact the **Office of the Commissioner of Insurance** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Alternatively, you can call (800) 236-8517 outside of Madison, or (608) 266-0103 in Madison, and request a complaint form.

Appendix

Optional Eligibility Provisions

These eligibility provisions do not apply to your coverage unless they are listed on your Benefit Summary. Contact your employer to determine if any of the Optional Eligibility Provisions apply to your coverage.

Disabled Dependent Coverage

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Disabled Dependent Coverage."

To provide coverage for your disabled dependents, Section 3, "Eligibility and Coverage of Employees and Their Dependents," is amended. A fifth item is added to the "Your Dependents" provision under "Eligibility and When Coverage Begins," and reads as follows:

Your Dependents

. . .

5. Your unmarried biological child, legally adopted child, stepchild, or legal ward who has attained the limiting age for coverage under this plan, but who meets **all** of the following:

   - He or she is permanently mentally disabled or permanently physically disabled.
   - He or she is incapable of self-sustaining employment.
   - He or she is chiefly dependent on you for at least 50% of his or her support.
   - He or she was continuously covered by the employer-sponsored group plan with routine vision coverage that this plan replaced.

   You must provide us with proof that the above-listed criteria is met within 31 days of the date that your dependent is initially eligible to enroll or within 31 days of the date he or she reaches the limiting age, and at any time we request it during the 2-year period that follows. After the 2-year period, we may request proof of ongoing eligibility on an annual basis.

Your dependents are eligible for coverage on the date your coverage takes effect. Their coverage will begin on the date your coverage takes effect if we have received your application for their coverage within the first 30 days of their eligibility.

Domestic Partner Coverage

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Domestic Partner Coverage."

Domestic partners and their children are eligible for coverage under this Certificate as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this Certificate. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the Certificate's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this Certificate. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this Certificate.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by **all** of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is, and has been for the past 6 months, publicly acknowledged and commonly recognized within the communities in which you live and work.
- You share financial resources and have agreed to be responsible for each other's common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, both of you must attest to all of the following on our *Designation of Domestic Partner* form:

1. You are both 18 years of age or older.
2. You are both mentally competent to make the declarations required by the form.
3. You are not related by blood closer than would bar marriage in the state of Wisconsin.
4. For at least the past 6 months, all of the following have been true:
    - You have lived together in the same dwelling unit.
    - Neither of you was married or legally separated in marriage.
    - Neither of you was a party to an action or proceeding for divorce or annulment.

- Neither of you was in another domestic relationship.
- You were financially interdependent as evidenced by at least two of the following:

    1. Common or joint ownership of a residence.
    2. Joint ownership of a motor vehicle.
    3. Joint credit account; for example, a credit card.
    4. Joint checking or savings account.
    5. Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
    6. Joint financial investments.
    7. Other evidence of mutual financial interdependency that we deem acceptable.

The signed *Designation of Domestic Partner* form is part of the contract of insurance. We reserve the right to verify the information at any time.

Your domestic partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your domestic partnership fulfilled all of the conditions we have described above.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on the information submitted.

The required documents are these:

1. An enrollment form, listing all individuals for whom you wish coverage.
2. The signed *Designation of Domestic Partner* form.

If we do not receive the required documents within 30 days of initial eligibility, the "Rules for Late Enrollments," described in Section 3, apply.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approve coverage for your domestic partner.

Certificate provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the *Designation of Domestic Partner* form.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this Certificate as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

Same Gender
Domestic Partner Coverage

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Same Gender Domestic Partner Coverage."

Domestic partners of the same gender and their children are eligible for coverage under this Certificate as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this Certificate. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the Certificate's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this Certificate. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this Certificate.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by **all** of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is, and has been for the past 6 months, publicly acknowledged and commonly recognized within the communities in which you live and work.
- You share financial resources and have agreed to be responsible for each other's common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, both of you must attest to all of the following on our *Designation of Same Gender Domestic Partner* form:

1. You are members of the same gender.
2. You are both 18 years of age or older.
3. You are both mentally competent to make the declarations required by the form.
4. You are not related by blood closer than would bar marriage in the state of Wisconsin.
5. For at least the past 6 months, all of the following have been true:
    - You have lived together in the same dwelling unit.

- Neither of you was married or legally separated in marriage.
- Neither of you was a party to an action or proceeding for divorce or annulment.
- Neither of you was in another domestic relationship.
- You were financially interdependent as evidenced by at least two of the following:
    1. Common or joint ownership of a residence.
    2. Joint ownership of a motor vehicle.
    3. Joint credit account; for example, a credit card.
    4. Joint checking or savings account.
    5. Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
    6. Joint financial investments.
    7. Other evidence of mutual financial interdependency that we deem acceptable.

The signed *Designation of Same Gender Domestic Partner* form is part of the contract of insurance, and we reserve the right to verify the information at any time.

Your domestic partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your domestic partnership fulfilled all of the conditions we have described above.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on the information submitted.

The required documents are these:

- An enrollment form, listing all individuals for whom you wish coverage.
- The signed *Designation of Same Gender Domestic Partner* form.

If we do not receive the required documents within 30 days of initial eligibility, the "Rules for Late Enrollments," described in Section 3, apply.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approve coverage for your domestic partner.

Certificate provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the *Designation of Same Gender Domestic Partner* form.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this Certificate as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

Coverage for Domestic Partners

(As Defined by Chapter 770 of the Wisconsin Statutes)

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Coverage for Domestic Partners (As Defined by Chapter 770 of the Wisconsin Statutes)."

Domestic partners and their children are eligible for coverage under this Certificate as dependents of covered employees. Domestic partners have the same rights, responsibilities, and entitlements as a legal spouse under this Certificate. If we approve a domestic partner's enrollment, his or her biological or legally adopted children who meet the Certificate's requirements for eligibility have the same rights, responsibilities, and entitlements as an employee's stepchildren under this Certificate. These covered dependents, the employee, and the employee's other covered dependents, if any, comprise a family as that term is used in this Certificate.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have obtained a declaration of domestic partnership issued by the county clerk, as described in Chapter 770 of the Wisconsin Statutes, and the partnership has not been terminated.

Qualifying for Eligibility as a Domestic Partner

To establish that an individual qualifies for eligibility as your domestic partner, you must provide us with a copy of the declaration of domestic partnership issued by the county clerk pursuant to Chapter 770 of the Wisconsin Statutes.

The copy of the declaration of domestic partnership is part of the contract of insurance. We reserve the right to verify the information at any time.

Your domestic partner is eligible for coverage on the later of these two dates:

- The date you are eligible for coverage.
- Within 30 days of the date the declaration of domestic partnership is recorded with the county register of deeds.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if **both** of the following apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on the information submitted.

The required documents are these:

1. An enrollment form, listing all individuals for whom you wish coverage.

2. A copy of the declaration of domestic partnership issued by the county clerk, pursuant to Chapter 770 of the Wisconsin Statutes.

If we do not receive the required documents within 30 days of initial eligibility, the "Rules for Late Enrollments," described in Section 3, apply.

Eligibility of Your Domestic Partner's Children

Biological or legally adopted children of your covered domestic partner are eligible for coverage as dependents on the same date as the domestic partner is eligible. Coverage for these children begins on the date they are eligible if **both** of the following apply:

- We receive your application for their coverage within 30 days after they first become eligible.

- We approved coverage for your domestic partner.

Certificate provisions that pertain to the stepchildren of a covered employee apply to your domestic partner's children. Therefore, they are eligible for coverage only as long as your domestic partner remains covered.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the earlier of these dates:

- The date your domestic partnership terminates, as described in Chapter 770 of the Wisconsin Statutes.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this Certificate as divorce or annulment of marriage, or the death of the covered employee. Therefore, the domestic partner and his or her children are no longer eligible for coverage after the last day of the month in which the domestic partnership ends.

Retired Employee Continuation

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Retired Employee Continuation."

This provision extends the coverage for you and your covered dependents beyond the date coverage would otherwise end, as described below.

If you retire at age 55 or older while you are covered by this Certificate as an active employee, your coverage will continue under this provision as long as all of the following apply:

- We receive your election to continue coverage under this option within 60 days of the date you retire.
- We receive the required premiums on time.
- We continue to insure the active employees in the occupational group within the class of eligible employees from which you retired.
- Your employer permits all retired employees within your class of eligible employees to continue coverage under this provision.

If you do not choose to continue coverage under this provision at the time you retire or you voluntarily terminate coverage under this provision at any time, you cannot re-enroll later, even during an open enrollment period.

Under this provision, the coverage you and your dependents are eligible to continue will be the same vision plan in effect for the active employees in the occupational group within the class of eligible employees to which you belonged while you were actively working.

The premium rate will be the same as the rate in effect, on each date that premium is due, for the class of eligible employees to which you belonged while you were actively working. You may be responsible for paying all or part of the required premiums for coverage.

If you continue coverage under this provision, the following rules will apply to your dependents:

- Your dependents are eligible to continue coverage as long as they continue to qualify as dependents under this Certificate.
- If you acquire an eligible dependent through marriage, birth of a child, or adoption or placement for adoption of a child, you may enroll your new eligible dependents if we receive the required enrollment form within 30 days of the date of the event. If we do, coverage for your eligible dependents will begin on the date of the event.

- You may otherwise enroll your eligible dependents during your employer's annual open enrollment period as explained under "Annual Open Enrollment" in Section 3, if they satisfy the required criteria.

Retired Employee Continuation—Limited Duration

This eligibility provision applies to your coverage only if your Benefit Summary indicates "Retired Employee Continuation—Limited Duration."

The "Retired Employee Continuation—Limited Duration" provision is the same as the "Retired Employee Continuation" provision, with two exceptions:

- Coverage will continue only for a limited period of time as specified by your employer for your class of eligible employees; and

- The minimum age you must attain prior to retirement to be eligible for coverage under this provision may be an age other than 55, if specified by your employer for your class of eligible employees.