WEA Trust

Essential Vision Plan

A WEA Insurance Corporation Group Vision Policy

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

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Important Notices

<u>KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS</u>

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 policy, we add the amendment to our online policies.

To view your policy, go to weatrust.com and click on "Policies." If you prefer to receive a paper policy, please call our Administrator, at the number identified on the following page.

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WEA Trust Essential Vision Plan
A WEA Insurance Corporation Group Vision Policy

This is a preferred provider group vision insurance policy. This document is a description of group vision insurance benefits. If you are a covered employee, then this insurance policy 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 policy and your Benefit Summary.

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

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.

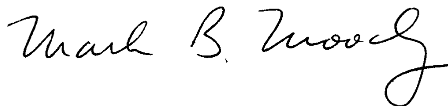
The eligibility criteria for coverage described in this policy may be changed by one or more of the Optional Eligibility Provisions that are located in the Appendix at the back of this document. The Benefit Summary indicates which Optional Eligibility Provisions, if any, apply to your coverage.

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

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

The WEA Insurance Corporation hereby agrees to provide benefits in accordance with all of the provisions, exclusions, and limitations of this policy.

WEA Insurance Corporation
Madison, Wisconsin



Mark Moody, President & CEO

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Section 1
Policyholder's Provisions: Rights and Obligations of the Employer and the WEA Insurance Corporation

This policy is a contract of insurance between the policyholder, referred to as the "employer," and the WEA Insurance Corporation, referred to as "we," "us," and "our." To the extent that our Administrator performs certain services, "we," "us," and "our," may also refer to our Administrator.

General Information About This Policy
This is a preferred provider group vision insurance policy. 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 policy.

This policy 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 policy.

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 policy, call our Administrator at (877) 262-7915.

Conditions of Issuance
This policy will take effect on the date, and in accordance with, the terms specified on the Group Vision Insurance Agreement between the employer and us if the following requirements are met. If these requirements are not maintained, we may terminate this policy.

1. The employer's plan that provides the benefits of this policy must satisfy the nondiscrimination requirements of I.R.C. sec. 501(c)(9) and sec. 505(b).

2. The employer must meet all minimum participation requirements we have established for this policy.

We will not permit this plan to be offered in a dual choice situation with another Trust or non-Trust plan without our prior written approval.

Minimum Participation Requirement
We reserve the right to nonrenew or terminate this policy, at our sole discretion, if participation drops below the following requirements:

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1. When employees are not required to contribute to the cost of their insurance, there must be 100% participation.

2. When employees are required to contribute to the cost of their insurance, at least 10 eligible employees are required to participate.

Before the nonrenewal or termination of this policy for failure to meet minimum participation requirements, we will notify the employer of the reason for the nonrenewal or termination, consistent with all statutory notice requirements.

When Premiums Are Due

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. The premium is due each month on or before the 20th day of the month that precedes the month of coverage. This payment deadline applies whether the premium is due from the employer or from a covered individual who pays his or her own premium directly to us.

Amount of the Premium

The monthly premium due is the sum of the premiums for all covered individuals. Premium is owed for each individual for each month in which he or she is covered by this policy for at least one day. Exception: When an employee's coverage begins after the 15th day of a month, the premium liability for that employee will begin on the first day of the following month.

The employer must notify us immediately whenever a covered employee ceases to be eligible for coverage. Depending on the event that caused the ineligibility, coverage for the employee will end either on the date the employee ceased to be eligible or on the last day of the month in which the employee ceased to be eligible. Premium liability will cease on the last day of the month of coverage. We will not be obligated to provide benefits to any individual who is not eligible for coverage even if premiums have been paid for that individual.

The premium will always be based on the rates for the benefits that are in effect on the date that the premium is due. We may establish a new rate for any or all of the policy's benefits on any of the following dates:

- Any policy renewal date, if we notify the employer at least 31 days before that date.

- Any date the premium is due, if previous rates have been in effect for at least 12 months and we notify the employer at least 31 days before that date.

- Any date on which we and the employer agree to materially change any provision of this policy.

- Any date on which a federal or state statute, or the governmental administration of a statute, materially changes any provision or term of this policy.

We will never increase premium rates by 25% or more without 60 days' notice to the employer.

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Grace Period

We will allow a grace period of 31 days for the receipt of any premium due after the first premium. This policy will continue in force during the grace period. The grace period will start on the first day of the month following the day the premium is due. There will be no grace period, however, if either we or the employer has given written notice of termination to the other as stipulated below.

Termination of the Policy by the Employer

The employer may terminate this policy on the first day of any month by giving us written notice at least 31 days before that date. Similarly, the employer may terminate coverage under this policy, on the first day of any month, for an occupational group(s) of employees that is specified in the Group Vision Insurance Agreement as eligible for coverage by giving us written notice at least 31 days before that date. If the employer does not pay the premium when it is due or within the grace period, this policy will terminate at the end of the grace period. The employer is liable for payment of all premiums due and unpaid, including the premium for coverage during the grace period, as well as the costs and reasonable legal fees we incur in collecting any premiums owed.

We may agree to waive the automatic termination of this policy resulting from nonpayment of premium. If we do, we have the right to charge interest on the delinquent premium, and the employer will be obligated to pay that interest. The interest rate charged will be the prime interest rate published in The Wall Street Journal on the first business day of that month plus 1%.

Termination or Nonrenewal of the Policy by Us

We will not terminate this policy midterm except for one or more of the following reasons:

- The employer's failure to pay premium when due.
- Fraud or misrepresentation by the employer.
- Substantial breaches of contractual duties, conditions, or warranties by the employer.
- The number of individuals covered under this policy is less than the minimum participation requirement established for this policy.
- The employer ceases operations.
- The employer has aligned this plan in a dual choice situation with another plan without our prior written approval.

If we terminate the policy for any of these reasons, we will give written notice to the employer at least 31 days before the termination date.

We have the right to change premium rates at renewal. We also have the right at renewal to alter the policy's benefit design consistent with that available to other policyholders as long as the

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alterations are not based upon the employer's particular claims experience. If we terminate the policy on any policy renewal date, we will give written notice to the employer at least 60 days before that date.

Employer's Duty to Furnish Information

The employer must furnish us with any information that we require to administer this policy. For example, the employer must notify us immediately whenever an employee's eligibility status changes. Examples include, but are not limited to:

- An employee becomes eligible for coverage.
- A change in job or hours renders an employee eligible for coverage.
- A covered employee is no longer eligible for coverage because of termination, retirement, reduction in hours, change in jobs, etc.
- A covered employee dies.

This information enables us to administer the policy and pay claims accurately.

We have the right to inspect, at any reasonable time, any of the employer's records that are relevant to administering this policy, including verification that the policy's minimum participation requirement is being met.

How Clerical Errors Will Be Handled

If, due to a clerical error, the employer fails to notify us of an employee who is eligible for coverage, that error will not deprive the employee and any dependents of coverage or affect their entitlement to benefits provided the error is corrected.

If, due to a clerical error, the employer fails to report the termination of coverage for an employee, that error will not extend coverage for the employee and any dependents beyond the appropriate termination date as defined by this policy. We will refund premium paid beyond the appropriate termination date for such an individual, up to a maximum of 6 months' premium, if claims were not paid during that time.

If, however, as a result of the employer's failure to report the termination of coverage for an employee, we pay claims beyond the appropriate termination date, the employer will pay premium for that employee's plan for the period of time up to and including the month during which we last paid claims or the employer reported the eligibility change to us, whichever is earlier. This will not change or extend any individual's legal rights with respect to group continuation coverage.

An employer's error will not create any liability whatsoever for us.

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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 policy. No statement or representation relating to the interpretation or application of any provision of this policy 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 policy and any Optional Eligibility Provisions.

2. The Benefit Summary.

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

4. The employer's application form.

5. The employees' enrollment forms.

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

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

If any policy 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 policy 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.

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Section 2
Definitions That Apply to All Provisions

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

Administrator means the entity which services the policy 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

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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 policy, it refers to any vision care professional service or correction Materials.

- Any time the words **"you"** or **"your"** appear in this policy, they refer to any individual who is covered by the policy. 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 policy.

- Any time the word **"covered"** appears in the benefit provisions of this policy, 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.

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Section 3
Eligibility and Coverage of Employees and Their Dependents

This section describes the individuals who are eligible for coverage under this policy. 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 policy. The waiting period, if any, is established by your employer and is specified in the Group Vision Insurance 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 policy. 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 policy. 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, 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 policy takes effect 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

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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 Group Vision Insurance Agreement.

Your coverage will begin on the date this policy takes effect 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 Group Vision Insurance 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 policy, 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 policy 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.

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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 policy. 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.

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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 policy, 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.** This will enable us to administer the policy and process claims accurately.
- **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 policy terminates for any reason.

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- 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.

- The date on which you enter the military forces of any state or country, including the United States, or are called to active duty as a member of a reserve unit of the armed forces for more than 30 days.

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

- The date on which your occupational group ceases to be part of the class of eligible employees specified by your employer on the Group Vision Insurance 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 policy.

- The date of your death.

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

- The date this policy terminates 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.

- The date of the divorce or annulment of your marriage terminates the coverage of your spouse.

- The date on which your dependent enters the military forces of any state or country, including the United States, or is called to active duty as a member of a reserve unit of the armed forces for more than 30 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.

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- 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

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or their “COBRA administrator” if you have questions related to federal continuation coverage, and/or eligibility for such coverage.

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Section 4
General Provisions That Apply to All Benefits

This policy 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

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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 policy 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

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listed on your Benefit Summary. This policy 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 policy 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 policy is in effect. Your Benefit Summary specifies the frequency limits that apply to certain covered services.

Policy Changes

If any policy 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 Policy Requirements

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

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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 policy 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.

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- 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 policy.
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 policy, except that vision correction Materials ordered before your coverage under this policy 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.

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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 policy covers vision examinations.

If vision examinations are covered, this policy 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 policy covers frames and Eyeglass Lenses, or Contact Lenses, prescribed by a licensed ophthalmologist or licensed optometrist for vision correction. The policy 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.

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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.

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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 policy, 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

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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.

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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 policy. This section explains the rights you have under this policy and by law to receive explanations of what your policy 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 policy, 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.

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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.

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Continuation Administration

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

Under this provision, we are the "COBRA administrator" for federal continuation coverage. Therefore, the "Your Legal Rights to Continuation Coverage" provision within Section 3, "Eligibility and Coverage of Employees and Their Dependents," is deleted and replaced with the following:

Your Legal Rights to Continuation Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides a temporary extension of coverage for qualified beneficiaries who lose coverage under an employer's group vision plan because of specified life events, called qualifying events. The terms qualified beneficiary and qualifying event are explained below. If you or your dependents lose coverage under this policy due to a qualifying event, you are entitled to continue coverage if **all** of the following apply:

- We receive timely notification of the qualifying event.
- You elect continuation coverage within the specified time limit.
- We continue to insure the active employees in the occupational group within the class of eligible employees to which you belonged on the day before your qualifying event.
- We receive the required premiums on time.

Under these circumstances, you may continue your coverage under this policy for a specified period. This subsection summarizes your rights and obligations regarding continuing coverage under this policy.

What is Continuation Coverage?

Continuation coverage is a temporary extension of coverage that can become available if you and/or your covered dependents would otherwise lose coverage under your employer's group plan. Continuation coverage is the same coverage given to other covered individuals who are in your occupational group of eligible employees but who have not experienced a qualifying event. Each qualified beneficiary who elects continuation coverage has the same rights and benefits under this policy as those covered individuals until his or her continuation coverage has ended.

Qualified Beneficiaries

A qualified beneficiary is an individual covered by this policy on the day before a qualifying event occurs, who will lose coverage because of that qualifying event. Qualifying events are listed below. Depending on which qualifying event occurs, you, your spouse, and/or your children, stepchildren, and legal wards may be qualified beneficiaries. An alternate recipient

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under a National Medical Support Order that we received while you were employed may also be a qualified beneficiary.

If you have a newborn child or a child placed with you for adoption while you are on continuation coverage, that child is also considered a qualified beneficiary. That child's coverage begins when the child is enrolled in this plan (see the rules for enrollment under "Your Dependents" earlier in this section) and lasts for as long as continuation coverage lasts for you and/or your other dependents. To enroll such a child, call our eligibility services department.

While you are on continuation coverage, you may also obtain coverage for a spouse or dependent child who becomes eligible for coverage under the terms of this policy, but such dependents are not qualified beneficiaries. You must apply for their enrollment within 30 days of the date they first become eligible. Coverage for these dependents ends when your continuation coverage ends, and they have no continuation rights of their own.

Qualifying Events

You will become a qualified beneficiary if you lose your coverage because of either of these qualifying events:

1. The termination of your employment for reasons other than gross misconduct.

2. A reduction in the number of your work hours.

Your spouse and/or dependent children will become qualified beneficiaries if they lose coverage because of any of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.

2. A reduction in the number of your work hours.

3. Your death.

4. Your divorce or the annulment of your marriage.

   Note: If an employee cancels a spouse's coverage in anticipation of divorce or annulment, and a divorce or annulment later occurs, the divorce or annulment will be considered a qualifying event even though the ex-spouse lost coverage earlier (in advance of the divorce or annulment). If the ex-spouse notifies us within 60 days after the date of the divorce or annulment and can establish that the employee cancelled the coverage earlier in anticipation of the divorce or annulment, continuation coverage may be available for the period after the divorce or annulment.

5. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

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Your Obligation to Notify Us When a Qualifying Event Occurs

We will offer continuation coverage to qualified beneficiaries only after we have been timely notified that a qualifying event has occurred. Depending on the qualifying event, either you or your employer is responsible for notifying us of its occurrence.

Your employer must notify us within 30 days of the date you experience any of the following qualifying events:

- The termination of your employment for reasons other than gross misconduct.
- A reduction in your work hours that results in the loss of coverage.
- Your death.

Important: You, your dependent, or your authorized representative must notify us within 60 days of the occurrence of either of the following qualifying events:

1. Your divorce or the annulment of your marriage.
2. Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

If you or your dependent does not provide the required notice within the 60-day period, following the "Notice Procedures" below, you and/or your dependents will lose your rights to COBRA continuation coverage.

After we receive your notice of a qualifying event, we will acknowledge it in writing within 14 days. We will send either a notice of your right to continue coverage or a letter explaining why you are not eligible to continue coverage.

Notice Procedures

You or your employer may provide any notice required by these continuation coverage provisions by calling or writing:

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

If mailed, your notice must be postmarked no later than the last day of the required notice period. If you give your notice by phone, you must call us no later than the last day of the required notice period. We will need this information when you call or write:

1. Your name and subscriber number.

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2. Your employer's name and group number, if known.

3. The specific qualifying event that is causing, or will cause, a loss of coverage.

4. The date of the qualifying event.

5. The names of all qualified beneficiaries who have lost or will lose coverage due to the qualifying event.

6. Your telephone number, address, and the addresses of any qualified beneficiaries if different from yours.

Duration of Continuation Coverage

The maximum period of continuation coverage depends on the qualifying event. You, your spouse, or dependent child may continue coverage for up to 18 months if coverage is lost because of one of the following qualifying events:

1. The termination of your employment for reasons other than gross misconduct.

2. A reduction in the number of your work hours.

Your spouse and/or dependent child may continue coverage for up to 36 months if they lose coverage because of one of the following qualifying events:

1. Your death.

2. Your divorce or the annulment of your marriage.

3. Your covered child, stepchild, or legal ward ceasing to qualify as a covered dependent.

Extension of the Period of Continuation Coverage

An 18-month period of continuation coverage can be extended under three circumstances. In all three circumstances, the extension applies only if the initial qualifying event was the termination of your employment or the reduction in your work hours.

Extension Due to a Second Qualifying Event

Spouses or dependent children who experience a second qualifying event while on continuation coverage may be eligible for up to an additional 18 months of continuation coverage, for a maximum of 36 months . An event can be a second qualifying event only if it would have caused your spouse and/or dependent child to lose coverage had the first qualifying event not occurred. The extension is available if the second qualifying event is one of these:

1. Your death.

2. Your divorce or the annulment of your marriage.

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3. Your covered child, stepchild, or legal ward ceasing to qualify as an eligible dependent.

Important: To obtain the extension, you or your dependent must notify us within 60 days after the second qualifying event occurs, using the "Notice Procedures" described in the box above. Failure to timely notify us will result in your dependent losing the right to extend coverage.

Extension Due to Disability
You and your dependents may receive up to an additional 11 months of continuation coverage, for a maximum of 29 months, if **both** of the following apply:

1. The Social Security Administration (SSA) determines you or your covered dependent to be totally disabled at any time during the first 60 days of continuation coverage. The SSA does not have to make its determination during the first 60 days. However, you or your dependent must be totally disabled, by SSA standards, at some point during those first 60 days, and the disability must last at least until the end of the 18-month period of continuation.

2. You notify us of the SSA determination of disability before the end of the original 18-month period of continuation coverage **and** within 60 days after the latest of these dates:

    - The date of the SSA determination of disability.

    - The date of the qualifying event (that is, the date of your termination or reduction in your work hours).

    - The date on which you lose coverage because of the qualifying event.

When you notify us, you must provide the name of the disabled qualified beneficiary, the date the qualified beneficiary became disabled, and the date the SSA made its determination. You must also provide a copy of the SSA's determination. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if any one of them qualifies. Failure to provide timely notice using the "Notice Procedures" earlier in this subsection will result in loss of the right to extend the period of coverage.

If the SSA later determines that the qualified beneficiary is no longer disabled, you must notify us of that fact within 30 days of the SSA's determination. If that determination occurs during the 11-month extension period, continuation coverage will terminate, retroactively if applicable, for all qualified beneficiaries as of the first of the month following 30 days after the SSA's determination. You will be required to repay all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled.

Extension Due to Your Medicare Entitlement
If you become entitled to Medicare benefits less than 18 months before you and your dependents lose coverage due to the termination of your employment or reduction in your work hours, federal law provides a special extension of continuation coverage for your dependents. In this instance, continuation coverage for your spouse and dependent children may last for up to 36 months from

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the date of your Medicare entitlement. This 36-month period is available only to your dependents, and only if you become entitled to Medicare within 18 months **before** the termination or reduction in hours. To obtain this extension, you or your dependent must notify us **before** the end of the initial 18-month continuation period.

How to Obtain Continuation Coverage

Within 14 days after we receive the required timely notice that a qualifying event has occurred, we will send a written offer of continuation coverage to each qualified beneficiary. We will mail this information to the most current address we have on file for you. Thus, to protect your rights, keep us informed of changes in your address. You should also keep a copy, for your records, of all notices you send to us.

Qualified beneficiaries will have a 60-day period, known as an election period, to elect to continue coverage under this policy. The election period will end 60 days after the **later** of these two dates:

- The date coverage ends as the result of the qualifying event.

- The date we send you information about your rights to continue coverage.

If you do not return your election notice indicating your choice to continue your coverage within that 60-day period, you will lose your right to elect continuation coverage.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, your spouse may elect continuation coverage even if you do not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You or your spouse, if your spouse is a qualified beneficiary, can elect continuation on behalf of all qualified beneficiaries.

Premiums for Continuation Coverage

Qualified beneficiaries are responsible for paying the premiums for continuation coverage. 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 working. Premiums will change on the annual renewal date of the employer's group under which you were/are covered, or when the benefits of the employer's group plan are changed.

The initial premium payment for continuation coverage is due 45 days after the election is made. This payment must include premiums for all months from the time you lost coverage under the employer's group plan through the current month of coverage. Claims will not be processed and paid until we have received your first premium payment. Qualified beneficiaries who do not make their first payments in full within this time limit will lose their coverage continuation rights.

All subsequent premium payments are due on the 20th of the month that precedes the month of coverage.

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A grace period of 31 days applies. The grace period starts on the first day of the coverage month for which the premium is due. We will provide continuation coverage for each month as long as we receive the premium for that month before the end of the grace period. If you do not pay the premium within the grace period, continuation coverage, and your rights to continuation coverage, will terminate.

If you or your dependents timely elect continuation coverage and pay premiums, the period of continuation coverage will begin the day after the qualifying event.

When Continuation Coverage Ends

A qualified beneficiary's continuation coverage under this policy will end on the earliest of the following dates:

- The end of the period for which the last premium was paid in full and on time.
- The date on which the applicable 18-month, 29-month, or 36-month period of continuation coverage ends.
- During an 11-month disability extension period, the first of the month following 30 days after the SSA determines the disabled qualified beneficiary is no longer disabled.
- The date on which the qualified beneficiary becomes covered under another group vision plan that does not impose any exclusion or limitation for a pre-existing condition of the qualified beneficiary.
- For a qualified beneficiary who becomes entitled to Medicare benefits while on continuation coverage, the date that is 18 months after the date continuation coverage begins.
- The date on which we no longer insure the active employees in the occupational group within the class of eligible employees to which the covered employee belonged on the day before the qualifying event.
- The date on which the employer ceases to provide any group vision coverage for the class of eligible employees.
- The date this policy terminates for any reason.

Qualified beneficiaries must notify us within 30 days if, after electing continuation coverage, they become covered under Medicare or another group vision plan (but only after any exclusion or limitation of that plan for a pre-existing condition of the qualified beneficiary has been exhausted or satisfied).

Continuation coverage will terminate, retroactively if applicable, as of the beginning of the other group coverage. Qualified beneficiaries will be required to repay all benefits paid after the termination date, regardless of whether or when they provided notice of other vision coverage.

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Exception That Applies to Domestic Partners

Domestic partners are not entitled by federal law to continuation of coverage when their coverage ends due to certain qualifying events. However, under this "Continuation Administration" provision, the policy provides continuation privileges to covered domestic partners and their covered biological or legally adopted children under circumstances, and for temporary periods, that are similar to those required by law for qualified beneficiaries.

Please note that we require you or your domestic partner to notify us in writing within 60 days of the date of the termination of the domestic partnership in order to preserve these dependents' rights to group continuation coverage. If we don't receive the written notice within the time period specified, continuation of coverage under this policy will not be offered.

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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 your tax dependent as defined by the United States Internal Revenue Service.
   - He or she was continuously covered by the employer-sponsored group plan with routine vision coverage that this policy replaced.

   You may continue coverage for your disabled child or legal ward as long as he or she continues to be both incapable of self-sustaining employment and chiefly dependent on you for support. In this case, you must provide us with proof of the incapacity and dependency 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 incapacity and dependency 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.

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

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.

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- 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 policy's "Rules for Late Enrollments," described in Section 3, apply.

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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.

Policy 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 policy 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 as of the date the domestic partnership ends.

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

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.

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- 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.

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If we do not receive the required documents within 30 days of initial eligibility, the policy's "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.

Policy 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 policy 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 as of the date the domestic partnership ends.

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

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.

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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 policy's "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.

Policy 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 policy 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 as of the date the domestic partnership ends.

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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 policy as an active employee, your coverage will continue under this provision as long as all of the following apply:

- 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.

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 are covered under this provision, you may voluntarily terminate this coverage at any time; however, you cannot re-enroll later.

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 policy.
- 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.

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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.

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