Voluntary Vision Insurance
Employee Benefit Booklet

NORTHWESTERN UNIVERSITY
F019106-0001
Class 1-01
Plan Custom- 12.12.12 $150
This plan is an "employee welfare benefit plan," ("Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document serves to provide important information about the Plan. It is not the entire Plan document, but a summary of important information about the Plan. In addition to this summary plan description ("SPD"), ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. Your employer or Plan Administrator maintains the full Plan Document. If there is a conflict between the Plan Document and this SPD, the Plan Document controls. A copy of the Plan Document is available for review during normal working hours in the office of the Plan Administrator.

The benefits described in your Plan document are provided under a group Plan sponsored by the Employer and insured by Blue Cross and Blue Shield of Illinois.

<table>
<thead>
<tr>
<th>SUMMARY PLAN DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. PLAN NAME:</strong></td>
</tr>
<tr>
<td>If different, the name by which the plan is commonly known.</td>
</tr>
<tr>
<td><strong>2. PLAN TYPE:</strong></td>
</tr>
<tr>
<td><strong>3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS:</strong></td>
</tr>
<tr>
<td>Name and address of employer sponsoring the Plan or employee organization maintaining the Plan</td>
</tr>
<tr>
<td><strong>4. EMPLOYER IDENTIFICATION NUMBER (EIN):</strong></td>
</tr>
<tr>
<td>Employer identification number assigned by the IRS to the Plan Sponsor</td>
</tr>
<tr>
<td><strong>5. PLAN NUMBER:</strong></td>
</tr>
<tr>
<td>Number assigned by the Plan Sponsor. This number is used for Form 5500 reporting. Each Plan should be assigned a unique number that is not used more than once.</td>
</tr>
<tr>
<td><strong>6. ERISA PLAN YEAR ENDS ON EACH:</strong></td>
</tr>
<tr>
<td>This is the end of the Plan Year for maintaining the Plan's fiscal records and may be different from the insurance policy year.</td>
</tr>
<tr>
<td><strong>7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:</strong></td>
</tr>
<tr>
<td><strong>8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:</strong></td>
</tr>
<tr>
<td><strong>9. SOURCES OF FUNDING AND CONTRIBUTIONS:</strong></td>
</tr>
<tr>
<td>Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.</td>
</tr>
<tr>
<td><strong>10. TYPE OF ADMINISTRATION:</strong></td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>11. CLAIM ADMINISTRATION:</strong></td>
</tr>
<tr>
<td><strong>12. EACH TRUSTEE'S NAME, TITLE, AND ADDRESS OF PRINCIPAL PLACE OF BUSINESS:</strong></td>
</tr>
<tr>
<td><strong>13. LABOR ORGANIZATION:</strong></td>
</tr>
<tr>
<td><strong>14. PLAN AMENDMENT AND TERMINATION PROCEDURE:</strong></td>
</tr>
<tr>
<td><strong>15. ELIGIBILITY FOR PARTICIPATION AND BENEFITS:</strong></td>
</tr>
<tr>
<td><strong>16. CIRCUMSTANCES CONCERNING INELIGIBILITY, DISQUALIFICATION, OR DENIAL OR LOSS OF BENEFITS:</strong></td>
</tr>
<tr>
<td><strong>17. CLAIMS PROCEDURES:</strong></td>
</tr>
</tbody>
</table>

SPD 9/2019 Revised
DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company, herein called “We” “Us” or “Our”)

Administrative Office Address: 701 E. 22nd Street, Lombard IL 60148

Having issued Group Policy No. F019106
(herein called the Policy)

to

NORTHWESTERN UNIVERSITY
(herein called the Policyholder)

GROUP VISION INSURANCE CERTIFICATE

CERTIFIES that You are insured, if You qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the Policy. Your insurance is subject to all the definitions, exclusions, limitations and conditions of the Policy, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This Certificate describes Your eligibility for benefits and the terms and provisions of the Policy. It replaces and cancels any other Certificate previously issued to You under the Policy.

If the terms and provisions of this Group Insurance Certificate (issued to You) are different from the Policy (issued to the Policyholder), the Policy will govern. Your coverage may be canceled or changed under the terms and provisions of the Policy.

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

[Signatures]

Secretary

President

Voluntary Group Vision Insurance Certificate
with Dependent Vision Benefits
Non-Participating

THIS IS A LIMITED BENEFIT POLICY

THIS IS NOT A WORKERS' COMPENSATION POLICY
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule of Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Eligibility and Effective Date Provisions</td>
<td>3</td>
</tr>
<tr>
<td>Vision Insurance Benefits</td>
<td>5</td>
</tr>
<tr>
<td>Limitations and Exclusions</td>
<td>6</td>
</tr>
<tr>
<td>Termination Provisions</td>
<td>7</td>
</tr>
<tr>
<td>General Provisions</td>
<td>9</td>
</tr>
<tr>
<td>Uniform Claim Provisions</td>
<td>11</td>
</tr>
<tr>
<td>General Definitions</td>
<td>13</td>
</tr>
<tr>
<td>Continuation of Coverage Rights under COBRA Notice</td>
<td>16</td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS

POLICYHOLDER: NORTHWESTERN UNIVERSITY

POLICY NUMBER: F019106

POLICY EFFECTIVE DATE: 01/01/2024

ANNUAL ENROLLMENT PERIOD: October 15 to November 15

PLAN YEAR: January 1 to December 31

ELIGIBILITY:

Class 01

All active full-time and part-time Employees, including Retirees that meet the parameters for eligibility of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time and part-time Employee, excluding Retirees is one who regularly works a minimum of 18.75 hours per week for the Policyholder. Seasonal and temporary Employees of the Policyholder are not eligible.

Eligibility Waiting Period:

All active full-time and part-time Employees

Current Employees: None

New Employees: First of the month following Date of Hire

All Retirees:

Current Retirees: None

New Retirees: None

Policyholder Contribution: Voluntary Vision 0% of premium

Coverage For: Employee, Spouse, and Dependent Child

Dependent Benefit amounts unless otherwise stated:

Spouse Benefits 100% of the Employee's benefit amount

Dependent Child Benefits 100% of the Employee's benefit amount

Live birth to age 26

Insured Persons have the right to obtain vision care from the Provider of his or her choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Examination*</td>
<td>$10 Co-payment</td>
<td>up to $40</td>
</tr>
<tr>
<td>Insured 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses Fit and Follow-Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>$10 Co-payment</td>
<td>up to $40</td>
</tr>
</tbody>
</table>

DNL10-VIC-0516 IL 1
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$10 Co-payment up to $40 allowance</td>
<td>up to $40</td>
</tr>
</tbody>
</table>

**VISION MATERIALS**

**Standard Plastic Lenses**  
Insured 12 months

<table>
<thead>
<tr>
<th>Type</th>
<th>Co-payment</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>$10</td>
<td>up to $40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10</td>
<td>up to $60</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10</td>
<td>up to $80</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$10</td>
<td>up to $80</td>
</tr>
<tr>
<td>Other Lenses (as developed)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Frames**  
Insured 12 months

<table>
<thead>
<tr>
<th>Type</th>
<th>Co-payment</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>up to $150 allowance</td>
</tr>
</tbody>
</table>

**Contact Lenses (only one option available per Benefit Frequency)**  
Insured 12 months

<table>
<thead>
<tr>
<th>Type</th>
<th>Co-payment</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>$0</td>
<td>up to $200 allowance</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0</td>
<td>up to $200 allowance</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0</td>
<td>up to $210</td>
</tr>
</tbody>
</table>

**Lens Options**  
Insured 12 months

<table>
<thead>
<tr>
<th>Type</th>
<th>Co-payment</th>
<th>Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Polycarbonate</td>
<td>$0</td>
<td>up to $5</td>
</tr>
<tr>
<td>Standard Polycarbonate (For covered Dependent Children under 19 years of age)</td>
<td>$0</td>
<td>up to $5</td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint, Solid or Gradient</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$0</td>
<td>up to $5</td>
</tr>
<tr>
<td>Standard Progressive Lenses (add on to Bifocal)</td>
<td>$75</td>
<td>up to $60</td>
</tr>
<tr>
<td>Premium Progressive Lenses (add on to Bifocal)</td>
<td>Tier 1 $95</td>
<td>up to $60</td>
</tr>
<tr>
<td></td>
<td>Tier 2 $105</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 $120</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 $75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>up to $120 allowance</td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td>$57</td>
<td>N/A</td>
</tr>
<tr>
<td>Photochromic Lenses</td>
<td>$75</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Covered Dependent Children are eligible for more than one exam within 60 days of the initial exam if prescription has changed by 0.50 diopter sphere/cylinder > 20 degrees axis, or visual acuity improvement by one line on standard chart.
ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?
The eligibility for this insurance is as indicated in the Schedule of Benefits.

The Eligibility Waiting Period is further defined in the Schedule of Benefits.

When does Your Contributory insurance become effective?
You may enroll for coverage during the Annual Enrollment Period, unless You qualify because of a Change in Family Status. Your Contributory coverage will become effective on the latest of the following dates if You are Actively at Work on that date:

1. If You enroll for coverage prior to the Policy Effective Date, the Policy Effective Date; or
2. If You enroll for coverage after the Policy Effective Date on the first of the month that falls on or next follows the date You sign the Enrollment Form; or
3. If You enroll during an Annual Enrollment Period, the next Anniversary Date following the Annual Enrollment Period.

Coverage requested because of a Change in Family Status will become effective on the first of the month that falls on or next follows the date You sign the Enrollment Form.

Change in Family Status
If You experience a Change in Family Status, You may enroll for coverage, apply for additional coverage, or request changes to Your current insurance coverage, provided the change is consistent with the Change in Family Status. For Your coverage to become effective, We must receive a completed Enrollment Form within 31 days of the Change in Family Status.

Change in Family Status means:
1. You get married; or
2. You have a Dependent Child, or You adopt or become the legal guardian of a Dependent Child; or
3. Your Spouse dies or You become divorced; or
4. Your Dependent Child becomes emancipated or dies; or
5. Your Spouse is no longer employed, resulting in a loss of group insurance; or
6. You have a change in employment classification which results in You changing from part-time to full time, or full-time to part-time employment.

When does Dependent coverage become effective?
Your Dependent’s coverage will become effective on the latest of:

1. The date Your coverage becomes effective under the Policy, if You have enrolled for Dependent coverage on or before that date; or
2. The first day of the month following the date You enroll for Dependent coverage.

When does coverage for a new Spouse become effective?
Coverage for a new Spouse starts automatically on Your marriage. Your new Spouse will be a Covered Person for 31 days. Your Spouse will cease to be a Covered Person unless:

1. You request, in writing within those 31 days continuation of such Dependent coverage; and
2. The required premium is paid. Premium will be charged from the date of marriage.

When does coverage for a newborn Child become effective?
If You have not previously elected Dependent Child coverage, coverage for a newborn Child starts automatically from the moment of birth if a Child is born to You. The newborn Child will be a Covered Person for 31 days. The newborn Child will cease to be a Covered Person after 31 days, unless:

1. You request in writing within those 31 days continuation of such Dependent Child coverage; and
2. The required premium is paid. Premium will be charged from the date of birth.
If You currently have Dependent Child coverage, Your newborn Child will be automatically added to Your coverage.

Dependent Child coverage will also be extended to newly adopted, foster or step Children, as of the date they become financially dependent on You for support, provided they otherwise meet the definition of a Dependent Child.

Will the Effective Date of coverage be delayed if Your Dependent is confined to a Hospital?
The Effective Date of coverage will be delayed if Your Dependent, other than a newborn Child, is confined in a Hospital on the date coverage would otherwise become effective. In such case, the Dependent’s coverage will become effective on the first day of the month that follows discharge from the Hospital.

What is an Annual Enrollment Period?
Unless otherwise specified, Annual Enrollment Period means a period of time during which Employees may enroll for coverage or request changes to their benefit plan. The Annual Enrollment Period is shown on the Schedule of Benefits.

Initial requests for coverage or requests for changes to existing coverage made during the Annual Enrollment Period will become effective on the next Policy Anniversary Date.

If You are not Actively at Work, when does coverage become effective?
If You are not Actively at Work on the date Your coverage would otherwise become effective, and Your absence is caused by an Injury, Illness or layoff, Your effective date for any initial coverage or increased coverage will be deferred until the first day You return to Active Work.

However, You will be considered Actively at Work on any day that is not Your regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if You were Actively at Work on the immediately preceding scheduled work day and You were:

1. not Hospital Confined; or
2. disabled due to an Injury or Sickness.

Eligibility after You Terminate Employment
If Your coverage ends due to termination of employment, You must meet all the requirements of a new Employee if You are rehired by the Policyholder at a later date.

What happens if We are replacing a Prior Policy?
Subject to the payment of premiums when due, We agree to waive the Actively at Work requirement if You:

1. were covered by a Prior Policy on the day immediately preceding the Policy Effective Date; and
2. You are on lay-off, non-medical leave of absence, or sabbatical leave; and
3. You are covered under an extension of benefits under the Prior Policy.

Coverage will continue for the first to occur of:
1. expiration of the balance of the extension of benefits under the Prior Policy; or
2. 12 months; or
3. the date the Policy terminates.

Prior Policy means the group vision insurance policy issued to the Policyholder immediately prior to the Effective Date of this Policy.

Changes to Your coverage
A change in Your coverage may occur if:

1. You enroll for a different benefit amount; or
2. there is a Policy change; or
3. You enter another class and become eligible for a change in benefits.
If You are eligible for additional coverage due to a Policy change, the additional coverage will be effective on the date the Policy change is effective, as requested by the Policyholder and agreed upon by Us.

If a change results in additional coverage, for reasons other than a Policy change, the change will be effective the first of the month following the later of:

1. The date You enroll for the additional coverage; or
2. The date You become eligible for the additional coverage, if enrollment is not required.

In order for Your additional coverage to begin, You must be Actively at Work. Additional Contributory coverage is subject to Our receipt of premium.

If a change results in a decrease in coverage the change will take effect immediately.

Exception: Increases or decreases to Your coverage made during the Annual Enrollment Period will become effective on the next Policy Anniversary Date, provided You are Actively at Work on that day.

VISION INSURANCE BENEFITS

Benefits are payable for each Insured Person, as shown in the Schedule of Benefits, for expenses incurred while this insurance is in force.

What are the In-Network Provider Benefits?
The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the company.

What are the Out-of-Network Provider Benefits?
The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the company. The company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

How Many Vision Examinations are Available?
An Insured Person is eligible for one Vision Examination in each Benefit Frequency.

What Vision Materials are Available?
If the Vision Examination covered by the Policy a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person’s visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

1. Lenses provided one time in each Benefit Frequency.
2. Frame(s) provided one time in each Benefit Frequency.
3. Contact Lenses provided one time in each Benefit Frequency in lieu of lenses, Contact Lenses Fit and Follow-Up benefits apply only for covered Contact Lenses.
LIMITATIONS

Limitations:

1. **Vision Examination** and/or **Vision Materials**. Fees charged by a **Provider** for services other than a covered benefit must be paid in full, by the **Insured Person**, to the **Provider**. Such fees or materials are not covered under the **Policy**.
2. Benefit allowances provide no remaining balance for future use within the same **Benefit Frequency**.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. medical and/or surgical treatment of the eye, eyes or supporting structures;
4. any eye or **Vision Examination**, or any corrective eyewear required by a **Policyholder** as a condition of employment; safety eyewear;
5. services provided as a result of any Workers’ Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
6. Plano (non-prescription) lenses and/or contact lenses;
7. non-prescription sunglasses;
8. two pair of glasses in lieu of bifocals;
9. services or materials provided by any other group benefit plan providing vision care;
10. certain name brand **Vision Materials** for which the manufacturer maintains a no-discount practice;
11. services rendered after the date an **Insured Person** ceases to be covered under the **Policy**, except when **Vision Materials** ordered before coverage ended are delivered, and the services rendered to the **Insured Person** are within 31 days from the date of such order; or
12. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next **Benefit Frequency** when **Vision Materials** would next become available.
**TERMINATION PROVISIONS**

**When does Your coverage under the Policy end?**

Your coverage terminates on the earliest of the following dates:

1. the date on which the Policy is terminated; or
2. the end of the month after the date You stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
4. the last day of the month on which the Participating Employer’s participation under the Policy is terminated; or
5. the earliest of:
   a. the date You die; or
   b. the end of the month after the date You are no longer a Member of a class eligible for this insurance; or
   c. the end of the month after the date You request termination of coverage under the Policy; or
   d. the first of the month following the date You reach age 99; or
   e. the end of the month after the date You are no longer Actively at Work as a result of a Disability, layoff, or leave of absence or sabbatical, or military leave or Reserve National Guard.

Termination will not affect an eligible claim for a covered Loss which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

**Disability**

Until the end of the twenty-fourth month following the month in which the Disability began, if all premiums are paid when due.

**Layoff**

Until the end of the twelfth month following the month during which the layoff began, if all premiums are paid when due.

**Leave of Absence**

Until the end of the month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the Policyholder’s Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.

**Sabbatical**

Until the end of the twenty-fourth month following the sixth month in which the sabbatical began, if all premiums are paid when due.

**Military Leave**

Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.

**Reserve National Guard**

If You are a member of an organized United States Reserve Corps or National Guard Unit, coverage will continue while You are:

1. In attendance at annual field training, cruise or other active duty training period of less than 60 days (except while attending a service school lasting beyond 60 days, in which case coverage will extend for the duration of the school); or
2. on the way to or from such training; or
3. participating in an authorized periodic inactive duty training, assembly or other inactive duty training authorized by unit orders; or
4. participating as a member of Your unit in an authorized parade, exhibition or ceremony.

For the purposes of this provision, Disability means You are unable to perform all of the Material and Substantial Duties of Your Regular Occupation.

**Will coverage be continued if You are eligible for leave under FMLA?**

In the event You are eligible for and the Policyholder approves a leave of absence under the Family and Medical Leave Act of 1993 and its amendments (FMLA), or any applicable state family and medical leave law provided the Policyholder continues to pay Your required premium, Your coverage will continue for a period of up to the later of:

1. the leave period permitted by the federal FMLA; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:
1. After the birth of a Child; or
2. After the legal adoption of a Child; or
3. After the placement of a foster Child in Your home; or
4. To a Spouse, Child or parent due to their serious Illness; or
5. For Your serious health condition; or
6. For any event later added by amendment to the Act.

During Your FMLA period:
1. The Policyholder must remit the premium required by the Policy; and
2. Coverage will terminate if You do not return to work as scheduled according to the terms of Your leave of absence agreement with the Policyholder.

When does Dependent coverage end?
Dependent coverage will end on the earliest of:
1. the last day of the month You are no longer an Employee (except in the case of Disability, layoff, or leave of absence or sabbatical, or military leave or Reserve National Guard as set forth above); or
2. the date on which the Policy is terminated; or
3. the last day of the month You stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
5. the last day of the month on which the Participating Employer’s participation under the Policy is terminated; or
6. the last day of the month You:
   a. are no longer a member of a class eligible for this insurance; or
   b. request termination of coverage under the Policy; or
   c. reach age 99; or
   d. are retired or pensioned; or
7. the date a Dependent Child or Spouse no longer meets the Policy definition of Dependent; or
8. the first of the month following 90 days after the date of Your death. Premium will not be payable during this period.

Coverage will continue past the age limit for Dependent Children who are primarily dependent on You for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to Us on request.
GENERAL PROVISIONS

Entire Contract; Changes
The Entire Contract consists of:
1. The Group Insurance Policy;
2. The Application;
3. This Certificate;
4. The Enrollment Forms of the persons Insured, including any individual statements; and
5. Any riders; endorsements; or amendments to the Policy or the Certificate.

Coverage under the Policy can be amended by mutual consent of the Policyholder and Us. No change in the Policy is valid unless approved in writing by one of Our officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application
All statements made in any signed Application, or other written and signed statement, are considered representations and not warranties (absolute guarantees). No representation by:
1. the Policyholder in applying for the Policy will make it void unless the representation is contained in the signed Application or other written and signed statement; or
2. any Employee in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of the Application for Insurance or other written and signed statement, if applicable, has been signed by the Employee and has been given to the Employee.

Legal Actions
Unless otherwise provided by federal law, no legal action brought to recover on the Policy of any kind may be filed against Us:
1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof must be filed, unless the law in the state where You live allows a longer period of time.

Clerical Error
Clerical error or omission by Us to the Policyholder will not:
1. Prevent You from receiving coverage, if You are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for You when the coverage would not otherwise be effective.

If the Policyholder gives Us information about You that is incorrect, We will:
1. Use the facts to decide whether You have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Incontestability
The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. No statement You made relating to Your insurability under the Policy will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force for two years during Your lifetime, and in no event unless the statement is contained in a written instrument signed by You and a copy is given to You or to Your beneficiary.

Premium Provisions
Premiums are payable in United States dollars on or before their due dates. The Policyholder has agreed to deduct from Your pay any premiums payable for Your Contributory coverage. The Policyholder agrees to and is responsible for remitting such premiums for the entire time coverage under the Policy is in effect.

Premium charges for increases in insurance amounts becoming effective during a Policy month will begin on the next premium due date. Premium charges for insurance terminating during a Policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have become effective or terminated.

Misstatement of Age
If You have misstated Your age or the age of a Dependent, the true age will be used to determine:
1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that You should have been paid if the true age had been known.

Conformity with State Statutes and Regulations
If any provision of the Policy conflicts with the statutes and regulations of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

Assignment
Benefits under the Policy may not be assigned.

00018
**UNIFORM CLAIM PROVISIONS**

**Initial Notice of Claim**
We must receive written notice of claim within 30 days of receiving services, or as soon as reasonably possible. The Policyholder can assist with the appropriate telephone number and address of Our Claim Department. Notice may be sent to Our Claim Department at the address shown on the claim form or given to any authorized agent of Ours.

**Claim Forms**
Within 15 days of Our being notified in writing of a claim, We will supply the claimant with the necessary claim forms. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written Proof only if We receive written Proof, which describes the occurrence, extent and nature of the loss for which claim is made.

**Proof of Loss**
We must receive written Proof within 90 days of the date You receive services or supplies. If it is not possible to give Us written Proof within 90 days, the claim is not affected if the Proof is given as soon as possible. However, unless the claimant is legally incapacitated, written Proof must be given no later than one year after the time Proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time Proof is due. However, benefits may be paid if it can be shown that:
1. It was not reasonably possible to give written Proof during the one year period, and
2. Proof was given as soon as was reasonably possible.

We will give You written response to Your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, We notify You in writing that an extension is necessary due to matters beyond Our control, identify those matters and gives the date by which We expect to render a decision. If the extension is due to Your failure to submit information necessary to decide Your claim, the time for decision shall be tolled from the date on which We send You notice of the extension until the date We receive Your response to Our request. This period will be no longer than 45 days after We have requested the information. At that time We will decide Your claim based on the information We have at that time.

**Who will receive Your Insurance Benefits?**
In-Network Provider benefits are payable to You or to Your Provider. Out-of-Network Provider benefits are payable to You. Any benefits payable on, or after, Your death, will be payable to Your Estate.

**Do I have the Right to Appeal a Claim Denial?**
If Your claim is denied, You will receive a written notice giving the following:
- the reason or reasons for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that You have to follow to have the claim reviewed;
- a statement that You have the right to bring a civil action under section 502(a) of ERISA after You appeal Our decision and after You receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to You upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request.

If the claim has been denied, You can appeal the denial to Us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:
- request a review upon written application within 180 days of the claim denial;
- request, free of charge, copies of all documents, records and other information relevant to Your claim; and
c. submit written comments, documents, records and other information relating to Your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after We receive Your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, We notify You in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If Your claim is extended due to Your failure to submit information necessary to decide Your claim on appeal, the time for Your decision shall be tolled from the date on which the notification of the extension is sent to You until the date We receive Your response to the request.

The decision on appeal will provide the following:
- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;
- a statement of the claimant’s right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to You upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request; and
- the following statement: “You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.”
GENERAL DEFINITIONS

**Actively at Work** or **Active Work** means that You must:
1. work for the Policyholder on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits and either:
   a. work at the Policyholder’s usual place of business; or
   b. work at a location to which the Policyholder’s business requires You to travel; and
3. not be a temporary or seasonal Employee; and.
4. be paid regular earnings by the Policyholder.

**Anniversary Date** means the annual month and day that corresponds with the Policy Effective Date.

**Annual Enrollment Period** means the annual timeframe defined in the Schedule of Benefits when Employees can make benefit changes.

**Application** means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied.

**Benefit Frequency** means the period of time in which a benefit is payable.

The Benefit Frequency begins on the plan year Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Certificate** means this Vision Insurance Certificate.

**Child(ren)** means:
1. Your natural or step Child under the age stated in the Schedule of Benefits; or
2. a Child under the age stated in the Schedule of Benefits placed with You for adoption from the date of placement or the date You are party in a suit in which You seek the adoption of the Child. Eligibility will continue unless the Child is removed from placement; or
3. a Child of Your Child who is Your dependent for federal income tax purposes at the time application for coverage of the Child of Your Child is made.

**Co-payment** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination and or Vision Materials per Benefit Frequency.

**Computer Display** means a personal computer monitor, personal laptop or mainframe terminal. It does not include any handheld electronic devices.

**Contributory** means You pay all or a portion of the premium for this insurance coverage.

**Covered Person** means an Employee or Eligible Dependent covered under the Policy.

**Dependent** or **Eligible Dependent** means:
1. Your lawful Spouse; and/or
2. Your Child(ren) who are not in active military service; and are within the age limits set forth in the Schedule of Benefits.
**Employee or Eligible Employee** means an *Actively at Work, full-time Employee* working in the United States of America as shown in the *Schedule of Benefits* whose principal employment is with the *Policyholder* and who is reported on the *Policyholder’s records* for Social Security and withholding tax purposes.

**Enrollment Form** means a form acceptable to *Us* that *You* complete to enroll for coverage under the *Policy*.

**Hospital** means either of the following:
1. A licensed facility which
   a. maintains on the premises everything necessary for major surgical treatment, and
   b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed *Physicians*; and
   c. provides 24-hour service by registered graduate nurses.
2. A free-standing surgical facility which maintains on the premises everything necessary for major surgical treatment available to the Hospital on a prearranged basis.

The term *Hospital* does not include an institution which is primarily a place for rest or convalescence, a place for the aged, a nursing home, a place for the treatment of alcohol or drug abuse or any facility primarily affording custodial, educational, or rehabilitative care.

**Hospital Confinement or Confinement** means the assignment to a bed as an inpatient in a *Hospital* on the advice of a *Physician* or confinement in an observation unit within a *Hospital* for a period of no less than 20 continuous hours on the advice of a *Physician*.

**In-Network Provider** means a *Provider* who has signed a *Preferred Provider Agreement* with the *PPO*.

**Insured(s)** means an *Employee* or *Dependent* covered under the *Policy*.

**Insured Person(s)** means the *Insured*. *Insured Person* will also include the *Insured’s Dependents*, if shown on the Insured’s identification card, if enrolled.

**Male Pronoun** whenever used includes the female.

**Material and Substantial Duties** means duties that are normally required for the performance of *Your Regular Occupation* which cannot be reasonably omitted or modified.

**Medically Necessary Contact Lenses** means:
1. Keratoconus where the *Insured Person* is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an *Insured Person* can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

**Out-of-Network Provider** means a *Provider*, located within the *PPO Service Area*, who has not signed a *Preferred Provider Agreement* with the *PPO*.

**Policy** means the contract between the *Policyholder and Us* including the *Application*, this *Certificate* and any amendments, riders or endorsements.
Policy Effective Date or Effective Date means the date stated on the Schedule of Benefits.

Policyholder means the person, firm, or institution to whom the Policy was issued. Policyholder also means any covered subsidiaries or affiliates set forth on the face of the Policy. If the Policyholder is an association the term Participating Employer shall be substituted for Policyholder.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Proof means evidence satisfactory to Us that the Covered Person has received services or supplies listed in the Schedule of Benefits.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Regular Occupation means the occupation that You are routinely performing when Your insurance terminates due to Disability. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for Your Policyholder or at Your specific location.

Schedule of Benefits means the schedule which is a part of this Certificate.

Spouse means lawful Spouse.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means those materials shown in the Schedule of Benefits.

Voluntary means coverage for which You pay 100% of the premium.

We, Our and Us means Dearborn Life Insurance Company.

You, Your and Yours means the Employee to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.
NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer’s group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:
● COBRA continuation coverage,
● When it may become available to You and Your family, and
● What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the Certificate or Certificate of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:
1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:
1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:
1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."
If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:
- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:
- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.
IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.
DEARBORN LIFE INSURANCE COMPANY
Chicago, Illinois

AMENDATORY ENDORSEMENT

This Rider, effective 01/01/2024, is part of the Certificate to which it is attached. It is subject to all provisions of the Certificate not in conflict with the provisions of this Rider.

This is a supplement to your Certificate of vision benefits. If you reside in New Mexico, please read this carefully as the benefits described in this Rider apply to you.

Laws in some states require that certain benefits be provided to you if you are a resident of that state but the Group Policy is issued in another state.

If you are a resident of the state of New Mexico, the Certificate, to which this Rider is attached and becomes a part, is amended as stated below to conform to the requirements of the state of New Mexico.

In the event of a conflict between the Certificate and the Rider, the provisions of the Rider will control. All other provisions of the Certificate continue to apply.

The Minimum Essential Coverage notice on the Face page has been revised to read as:

THIS TYPE OF PLAN IS NOT CONSIDERED MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE THAT YOU HAVE HEALTH INSURANCE COVERAGE.

The following Right to Review notice has been added to the Face page:

RIGHT TO REVIEW

YOU HAVE THE RIGHT TO RETURN THE PLAN WITHIN 30 DAYS OF DELIVERY, AND TO HAVE THE PREMIUM AND ANY REQUIRED MEMBERSHIP FEES REFUNDED, IF AFTER EXAMINATION OF THE PLAN YOU ARE NOT SATISFIED FOR ANY REASON, PROVIDED NO CLAIM HAS BEEN PAID.

Throughout the certificate:
1. All instances of “Provider(s)” have been replaced with “Vision Care Provider(s).”
2. All instances of “Vision Examination” have been replaced with “Comprehensive Vision Examination.”
3. All instances of “Vision Material(s)” and “supply(ies)” have been replace with “Covered Material(s).”
4. All instances of “Service(s)” have been replaced with “Covered Service(s).”
5. Dependent Children are covered up to age 26.

In the ELIGIBILITY, Class # section in the SCHEDULE OF BENEFITS, the last sentence has been revised to read as:

Seasonal and temporary Employees of the Policyholder are not eligible.

In the ELIGIBILITY, Class # section in the SCHEDULE OF BENEFITS, the following provision has been added:

Regular part-time Employees who work or are expected to work an average of at least twenty hours per week over a six-month period are not eligible.

In the Coverage section in the SCHEDULE OF BENEFITS under Dependent Benefit amounts unless otherwise stated, dependents are covered from live birth up to age 26.

The Portability Benefit has been removed from the SCHEDULE OF BENEFITS.

In the OUT-OF-NETWORK column in the SCHEDULE OF BENEFITS, Reimbursement has been added before the coverage amounts.

DL9-VIC-ET-AMEND NM 1121
In the SCHEDULE OF BENEFITS, the Insured, Dependent Spouse and Dependent Children receive a Comprehensive Vision Examination once every 12 months.

In the SCHEDULE OF BENEFITS, the Insured, Dependent Spouse and Dependent Children receive the following benefits every 12 months:

1. Retinal Imaging Examination; and
2. Contact Lenses Fit and Follow-up.

In the SCHEDULE OF BENEFITS, benefits for Other Benefits that may be added by Rider and Other Exams (as developed) have been deleted.

In the VISION MATERIALS section under Standard Plastic Lenses in the SCHEDULE OF BENEFITS, Other Lenses (as developed) has been deleted.

In the VISION MATERIALS section in the SCHEDULE OF BENEFITS, Contact Lenses has been changed to Elective Contact Lenses (only one option available per Benefit Frequency).

In the VISION MATERIALS section under Elective Contact Lenses in the SCHEDULE OF BENEFITS, a benefit has been added for Medically Necessary Contact Lenses paid in full In-Network. The minimum reimbursement for Out-of-Network is $50.00.

In the VISION MATERIALS section under Elective Contact Lenses in the SCHEDULE OF BENEFITS, the minimum reimbursement amount for all Elective Contact Lenses is $50.

In the VISION MATERIALS section under Contact Lenses in the SCHEDULE OF BENEFITS, the benefit for Other Contact Lenses (as developed) has been deleted.

In the VISION MATERIALS section under Lens Options in the SCHEDULE OF BENEFITS, the following benefits have been deleted:

1. Other Premium Progressive Lenses (as developed);
2. Other available Premium Anti-Reflective Coating; and
3. Other Lens Options (as developed).

In the provision, Who is eligible for this insurance? in the ELIGIBILITY AND EFFECTIVE DATE PROVISIONS section, the last sentence has been revised to read as:

Seasonal and temporary Employees of the Policyholder are not eligible.

In the provision, Who is eligible for this insurance? in the ELIGIBILITY AND EFFECTIVE DATE PROVISIONS section, the following provision has been added:

Regular part-time Employees who work or are expected to work an average of at least twenty hours per week over a six-month period are not eligible.

In the provision, When does coverage for a newborn Child become effective? in the ELIGIBILITY AND EFFECTIVE DATE PROVISIONS section, the last sentence has been revised to read as:

Dependent Child coverage will also be extended to newly adopted, foster or step Children, as of the date they become a Dependent Child.

The Portability Benefit has been deleted from the Eligibility after You Terminate Employment provision in the ELIGIBILITY AND EFFECTIVE DATE PROVISIONS section.

The following provision has been added to the VISION INSURANCE BENEFITS section:

Our member portal gives access to benefit details, claims, provider locations and more. Access vision benefit information at www.eyemedvisioncare.com/bcbsnmvis.

Spectacle and contact lens treatments and coatings have been added as item #4 under the What Covered Materials are Available? in the VISION INSURANCE BENEFITS section.
The following provision has been added under the **What Covered Materials are Available?** in the VISION INSURANCE BENEFITS section.

Frames, lenses, and contact lenses may be covered more often than indicated if deemed **Medically Necessary** by the Vision Care Provider.

The **ENHANCED BENEFITS** provision under the **What Covered Materials are Available?** in the VISION INSURANCE BENEFITS section has been deleted.

The limitation for **Comprehensive Vision Examination** and/or **Covered Materials** have been deleted from item #1 in the LIMITATIONS section.

The limitation for benefits not being covered for 30 days from the Insured Person’s Effective Date, has been deleted from the LIMITATIONS section.

The exclusion for any **Comprehensive Vision Examination** and **Covered Materials** has been deleted from the EXCLUSIONS section.

The **PORTABILITY BENEFIT** section has been deleted in its entirety.

The **Portability Benefit** has been deleted from the **When does Your coverage under the Policy end?** provision in the TERMINATION PROVISIONS section.

The sentence referring to **Participating Employers** has been deleted from the **When does Your coverage under the Policy end?** provision in the TERMINATION PROVISIONS section.

The **Portability Benefit** has been deleted from the **When does Dependent coverage end?** provision in the TERMINATION PROVISIONS section.

The sentence referring to **Participating Employers** has been deleted from the **When does Dependent coverage end?** provision in the TERMINATION PROVISIONS section.

The **Incontestability** provision has been changed to **Time Limit on Certain Defenses** in the GENERAL PROVISIONS section.

**A Time of Payment of Claim** provision has been added to the UNIFORM CLAIM PROVISIONS section.

The definition of **Child(ren)** in the DEFINITIONS section has been revised to read as:

**Child(ren)** means:

1. Your natural or step Child or Child of Your Registered Domestic Partner up to age 26; or

2. a Child up to age 26 placed with You for adoption from the date of placement or the date You are party in a suit in which You seek the adoption of the Child. Eligibility will continue unless the Child is removed from placement; or

3. a Child of Your Child who is Your dependent at the time application for coverage of the Child of Your Child is made; or

4. a newborn or newly adopted Child. Coverage for such a Child will begin on the date of birth for a biological Child or the date of placement or the date You are a party in a suit in which You seek the adoption of the Child. Eligibility will continue unless the Child is removed from placement; or

5. a Child for whom You are not the custodial parent; or

6. a Child for whom You have received a court or administrative order to maintain financial responsibility for providing health insurance.

**Coverage for Children of Non-Custodial Parents**

*We* will not deny enrollment of a child under the health plan of the child’s parent on the grounds that the child:

1. was born out of wedlock;
2. is not claimed as a dependent on the parent’s federal tax return; or
3. does not reside with the parent or in Our service area.

When a child has health coverage through an insurer of a noncustodial parent, We will:
1. provide such information to the custodial parent as may be necessary for the child to obtain benefits;
2. permit the custodial parent or the provider, with the custodial parent’s approval, to submit claims for Covered Services without the approval of the noncustodial parent; and
3. make payments on claims submitted directly to the custodial parent, the provider, or the state Medicaid agency.

Coverage for Children When Mandated by a Court or Administrative Order

When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, We will permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment period restrictions.

If the parent is enrolled but fails to make application to obtain coverage for the child, We will enroll the child under family coverage upon application of the child’s other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. sections 651 through 669, the child support enforcement program.

We will not:
1. disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:
   a. the court of administrative order is no longer in effect; or
   b. the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.
2. impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the Medicaid program and covered for health benefits that are different from requirements applicable to an agent or assignee of any other individual covered.

The definition of Covered Materials in the DEFINITIONS section has been revised to read as:

Covered Materials means those materials shown in the Schedule of Benefits and are reimbursable by a vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation.

The following definition of Covered Services has been added to the DEFINITIONS section:

Covered Services means services that are reimbursable by a vision plan vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation.

The definition of Dependent or Eligible Dependent in the DEFINITIONS section has been revised to read as:

Dependent or Eligible Dependent means:
1. Your lawful Spouse or Registered Domestic Partner; and/or
2. Your Child(ren) who are not in active military service and are up to age 26.

The following definition of Medically Necessary or Medical Necessity has been added to the DEFINITIONS section:

Medically Necessary or Medical Necessity means health care or vision services determined by a Vision Care Provider, in consultation with Us , to be appropriate or necessary, according to:
1. Any applicable generally accepted principles and practices of good medical/vision care;
2. Practice guidelines developed by the federal government, national or professional medical societies, boards, and associations; or
3. Any applicable clinical protocols or practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical illness, injury, or disease.

The definition of Member in the DEFINITIONS section has been deleted in its entirety.

The definition of Participating Employer in the DEFINITIONS section has been deleted in its entirety.

The definition of Participation Agreement in the DEFINITIONS section has been deleted in its entirety.

The definition of Policyholder in the DEFINITIONS section has been revised to read as:

Policyholder means the person, firm, or institution to whom the Policy was issued.

The definition of Provider in the DEFINITIONS section has been revised to read as:

Vision Care Provider means an individual licensed under state law as an optometrist or ophthalmologist.

President

Nothing contained in this Rider shall be held to alter or affect any provision or condition of your coverage other than as stated above.
NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary description of the Illinois Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Illinois law which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- **Life Insurance**
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 for health benefits plan*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits

- **Annuities**
  - $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at www.ilhiga.org or contact:

<table>
<thead>
<tr>
<th>Illinois Life and Health Insurance Guaranty Association</th>
<th>Illinois Department of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>901 Warrenville Road, Suite 400</td>
<td>4th Floor</td>
</tr>
<tr>
<td>Lisle, Illinois 60532-4324</td>
<td>320 West Washington Street</td>
</tr>
<tr>
<td></td>
<td>Springfield, Illinois 62767</td>
</tr>
</tbody>
</table>

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.
END OF CERTIFICATE
STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq., as amended (“ERISA”). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits
   a. Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries
   In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

3. Enforce Your Rights
   If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
   Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
   If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions
   If You have any questions about Your Plan, You should contact the Plan Administrator. If You have questions about this statement or about rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
ERISA INFORMATION STATEMENT

The benefits described in Your certificate are insured by an Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Illinois ("We" or "Insurer"), pursuant to an "Employee welfare benefit plan" ("the Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1) established by Your employer, or where applicable, employee organization (the “Policyholder”).

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to You pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.
B. CLAIMS PROCEDURE:

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Blue Cross and Blue Shield of Illinois
701 E. 22nd Street
Lombard, IL. 60148
1-800-367-6401

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).
Administrative Office:
701 E. 22nd Street
Lombard Illinois 60148

Principal Office:
300 E. Randolph Street
Chicago Illinois 60601