DELTA DENTAL®

EyeMed VISION CARE®

DeltaVision Handbook

Delta Dental of Wisconsin

DeltaVision Contact Information

Benefits & Information

Contact EyeMed's Customer Care Center for questions concerning benefits, claims payments, and ID cards.

Toll-free: **866-723-0514**

EyeMed Hours: **Monday-Saturday 7 a.m. to 10 p.m. (CT)**
Sunday 10 a.m. to 7 p.m. (CT)

Provider Locations

For a list of the most convenient EyeMed Vision Care provider locations, members may visit the Delta Dental website, or the EyeMed Vision Care website, or call EyeMed customer service (number and hours listed above).

Delta Dental: **www.deltadentalwi.com/provider-search/vision**

EyeMed: **www.eyemedvisioncare.com/memweb/ProviderLocator**

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Welcome

DeltaVision is offered through Wyssta Insurance Company, Inc., a wholly-owned subsidiary of Delta Dental of Wisconsin, Inc. Claims processing, claims service, and network administration for DeltaVision are handled through an agreement with EyeMed Vision Care, LLC.

Wyssta Insurance Company, Inc. has been selected by your employer to provide your group vision coverage. We are pleased to bring these important Benefits to you and any Dependents you have enrolled for coverage.

It is important for you to read this Vision Benefit Handbook with the Summary of Benefits page inserted. The Summary of Benefits lists the specific Benefits of your group vision coverage. Together, the Vision Benefit Handbook and the Summary of Benefits comprise your Certificate of insurance.

This Certificate is not the insurance policy. It is merely evidence of insurance provided under the Contract between Wyssta and your employer. All Benefits are paid according to the terms, conditions, and provisions of your Group's Contract. This Certificate describes the essential features of such insurance. This Certificate replaces and supersedes all Certificates, endorsements, and riders that we may have previously issued to you prior to the effective date of this Certificate.

The Contract issued to your employer is the complete document of insurance and governs all claims processing. It will serve as Wyssta's primary resource when answering questions regarding your vision claims. You may examine your Group's Contract any time by contacting your employer or Wyssta during normal business hours.

All claims are settled based on a specific methodology. The eligible amount of a claim may be less than the provider's billed charge.

If a clerical error or other administrative mistake occurs, that error will not deprive you of coverage under the policy that you would otherwise have had. A clerical error or other administrative mistake also will not create coverage that does not otherwise exist under the policy.

Definitions

"Allowance" means the amount or percentage shown in the Declarations and Summary of Benefits for vision Benefits that Wyssta will pay toward the applicable vision service or product provided.

"Benefit" or **"Benefits"** means those vision Benefits that are covered by Wyssta under the terms of your Group's Contract as specified in the Declarations and Summary of Benefits.

"Certificate" means the Vision Benefit Handbook and Summary of Benefits issued to a Subscriber insured through the Group. The Certificate outlines the Benefits provided by your Group's Contract.

"Contract" means the Master Group Contract, Declarations, and any endorsements attached to the Master Group Contract, together, and constitutes the policy of insurance issued by Wyssta to your Group.

"Copayment" means the dollar amount or percentage shown on the Declarations and Summary of Benefits that the Subscriber or Covered Dependent is required to pay directly to an EyeMed Vision Provider or a Non-Contracted Vision Provider for each service or product received that is a Benefit under the contract, as specified in the Declarations. The Copayment is applied to the fee for Benefits that Wyssta contracts with the EyeMed Vision Provider to pay or to the Allowance for Benefits, whichever is applicable.

"Covered Dependent" means a Dependent who (a) is listed in the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta as a Covered Dependent, and (c) for whom the appropriate premium has been paid.

"Dependent" means a person other than the Eligible Employee who has satisfied the criteria for eligibility to enroll for coverage under your Group's Contract.

"Eligible Employee" means an employee or member of the Group who has satisfied the criteria for eligibility to enroll for coverage under your Group's Contract.

"Emergency" and **"Urgent"** means a serious condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate professional attention will likely result in any of the following: (a) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; (b) serious impairment to the person's bodily functions; or (c) serious dysfunction of one or more of the person's body organs or parts.

"EyeMed Vision Provider" means a vision care provider who has entered into an agreement with EyeMed Vision Care, LLC ("EyeMed") to provide Vision Benefits through Wyssta to Subscribers and Covered Dependents.

"Grievance" means any dissatisfaction with the administration, claims practices, or provision of services by Wyssta that is expressed by telephone or in writing by or on behalf of a Subscriber or Covered Dependent.

"Group" means the employer, association, union or other organization contracting with Wyssta to provide Benefits to its Eligible Employees or members and their Dependents, if applicable.

"Non-Contracted Vision Provider" means a vision care provider who is not a member of EyeMed's provider networks.

"Open Enrollment Period" means an enrollment period during which time any Eligible Employees and/or Dependents may apply to become Subscribers and/or Covered Dependents, and existing Subscribers may apply to change to another provider network or coverage option, if available, or elect to terminate coverage.

"Subscriber" means an Eligible Employee or member of the Group who (a) has completed and signed the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta as a Subscriber, and (c) for whom the appropriate premium has been paid.

"Summary of Benefits" is a listing of the specific Benefits and Benefit limitations for vision Benefits provided under the terms of your Group's Contract. The Summary of Benefits is provided as an insert with the Vision Benefit Handbook.

"Urgent Care Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by Wyssta that requires immediate attention. An Urgent Care Grievance must be delivered to Wyssta in writing or by telephone. See the Grievance Procedure section of this Vision Benefit Handbook.

"Wyssta" means Wyssta Insurance Company, Inc.

"You" and **"Your"** means the Subscriber.

Filing a Claim

Using an In-Network Provider

Follow these simple steps to access your in-network vision Benefits:

1. Present your EyeMed card to your provider and provide your name, Employee Identification Number, or Date of Birth.
2. Your provider will confirm your eligibility as a DeltaVision Plan member.
3. You will receive services and your provider will calculate any out-of-pocket expenses after the Benefit has been applied. You are responsible for any out-of-pocket expenses at the time of service.
4. Your provider takes care of the rest.

Using an Out-of-Network Provider:

When you visit an out-of-network provider you may file a claim as follows:

1. Pay in full for services and materials to your out-of-network provider at the time of service.
2. Request an itemized receipt from your provider.
3. Contact EyeMed via phone or website to obtain a claim form.
4. Submit the total claim on the EyeMed claim form, attaching the itemized receipt.
5. You will be reimbursed by EyeMed at out-of-network DeltaVision Plan Benefit levels.

Applicability of Allowances

Vision Benefit Allowances are available for a single application toward the cost of vision services and materials covered under this Plan. Any Allowance balance remaining may not be applied to any other services.

Covered Vision Procedures

Only vision procedures indicated as Benefits on your Summary of Benefits insert are covered under your Group's Contract.

Covered vision Benefits are subject to the limitations described in the Summary of Benefits insert and the exclusions outlined in this Vision Benefit Handbook. The Company will pay up to the Allowance shown in the Summary of Benefits for Vision Benefits and Subscriber or Covered Dependent will be responsible for any remaining amount.

Subscriber or Covered Dependent will also be responsible for any vision care products and services that are not Benefits under the Contract regardless of whether the vision care services were provided by an EyeMed Vision Provider or a Non-Contracted Vision Provider.

Exclusions

1. Any vision procedures, supplies, treatment, or any other services, as applicable, provided or commenced prior to the effective date of Subscriber's or Covered Dependent's coverage under the Contract.
2. Any vision procedures, supplies, treatment, or any other services to treat injuries or conditions compensable under worker's compensation or employer's liability laws.
3. Charges for completion of forms.
4. Charges for consultation.
5. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
6. Aniseikonic lenses.
7. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
8. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under your plan.
9. Plano nonprescription lenses and nonprescription sunglasses.
10. Benefits combined with any discount, promotional offering, or other group benefit plans.
11. Lost or broken materials.
12. Any vision procedures, supplies, treatment, or any other services, as applicable, except as provided in the Declarations and Summary of Benefits.
13. Procedures not specifically covered under this Contract.

Eligibility

Covered Employee

You are eligible for coverage under your Group's Contract while you are a regular employee of the Group who averages the number of hours as determined by the Group's Contract and who has completed any waiting period indicated on the Summary of Benefits.

You may also be covered by your Group's Contract if you no longer meet these conditions but have elected to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Covered Dependents

If you are enrolled for family coverage, the following persons may be covered under your Group's Contract as your Dependents:

1. Your lawful spouse.

2. Your children (including any children's children until your child is 18), including step and adopted children and children placed for adoption with you, who are less than 26 years of age.

3. Notwithstanding 1 and 2 above, your adult Dependent children, including step and adopted children and children placed for adoption with you may be covered under this policy if the adult child satisfies all of the following:
   (a) The child is a full-time student, regardless of age; and
   (b) The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher learning; and
   (c) The child re-enrolled as a full-time student within 12 months of returning from active duty.

4. A Dependent child over age 26 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 26, provided a physician's certificate of disability is submitted within six months following the Dependent child's 26th birthday. The Company reserves the right to request proof of continued disability from time to time, but not more often than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

Dependents in military service are not covered by your Group's Contract.

Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. Please see the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Effective Dates of Coverage

You are covered by your Group's Contract beginning on the first day the Contract becomes effective or as determined by your Group's Contract.

Your Eligible Dependents are covered beginning on the first day you become covered under your Group's Contract if you elect coverage for them. A newborn is covered at birth and coverage continues for 60 days. If an additional premium is required to cover the newborn, you must make written request to Wyssta and pay the required premium within 60 days of the birth. You may, however, request coverage for a newborn after the 60-day period but within one year of the birth provided you pay any required premium including an interest rate of 5.5%. If you adopt a child, coverage begins on the day the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first. Changes in enrollment due to birth or adoption must be received by Wyssta within 60 days of the birth or adoption.

An Eligible Employee who waived coverage because he/she was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The Eligible Employee must apply for such change in coverage within 30 days of the event causing the loss of the other coverage.

Changes in Coverage

You may change your enrollment in this vision Plan if you experience a Qualifying Event such as a change in marital status, the acquisition of a Dependent, or the loss of coverage through your spouse's Plan. The enrollment change will be effective the first of the month following the Qualifying Event. Notification of this enrollment change must be received by Wyssta within 30 days of the Qualifying Event.

You may change your enrollment without a Qualifying Event if you contribute toward your premium and if an Open Enrollment Period is offered by the Group. Elective coverage changes can be considered by Wyssta only at that time.

Notices

Notice to your employer or Wyssta will be considered sufficient if mailed to each party's regular office address. Notices to you, as a Subscriber, will be considered sufficient if mailed to your last known address or the last known address of your Group. It is the responsibility of your Group to notify you regarding changes to or termination of your coverage.

Termination of Coverage

Your coverage and that of your Covered Dependent(s) ceases on the day you or your Covered Dependent(s) are no longer eligible or the day your Group's Contract is terminated.

If you or your Dependent(s) lose eligibility under the Plan, you or your Dependent(s) may elect to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Continued Coverage

Under Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Subscribers and Covered Dependents in employer groups of more than twenty employees ("Qualified Beneficiaries") are permitted to elect continuation of vision coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

Subscriber:

(1) Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or

(2) Reduction in hours to fewer than the minimum required to be an Eligible Employee under this Contract.

Covered Dependents:

(1) If the Covered Dependent is the Subscriber's spouse:

(a) Death of Subscriber; or

(b) Termination of Subscriber's employment, except for reasons of gross misconduct; or

(c) Reduction of Subscriber's hours to fewer than the minimum required for eligibility for coverage under this Contract; or

(d) Divorce or legal separation from Subscriber; or

(e) Subscriber's Medicare entitlement.

(2) If the Covered Dependent is the Subscriber's child:

(a) Child ceases to be a Dependent; or

(b) Death of Subscriber; or

(c) Termination of Subscriber's employment, except for reasons of gross misconduct; or

(d) Reduction in Subscriber's hours to less than the minimum required to be eligible as a Subscriber under this Contract; or

(e) Subscriber becomes entitled to Medicare; or

(f) Parents become divorced or legally separated.

The Group must provide notice to the Subscriber and to Covered Dependent(s), as applicable, of the right to elect COBRA continuation coverage.

A Covered Dependent whose coverage is terminated due to divorce, legal separation or cessation of eligibility for Dependent coverage must provide the Group notice of such event within 60 days of its occurrence.

An election of continuation coverage must be made within 60 days beginning on the later of the date of the Qualifying Event or the date the Subscriber receives notice of election rights. The COBRA election by a Subscriber or covered spouse is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Covered Beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the COBRA coverage begins on the date of the Qualifying Event and ends on the earlier of:

(1) 18 months after the Subscriber's employment termination or reduction in hours.

(2) 29 months after the Qualifying Event for (a) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at anytime during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for (b) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event.

(3) For Qualified Beneficiaries other than the Subscriber, 36 months after the date of the initial Qualifying Event for all other Qualifying Events.

(4) The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of premium. Wyssta will not reinstate COBRA continuation coverage once terminated for nonpayment of premium.

(5) The date on which the Group ceases to offer this Contract to any of its employees or members.

(6) The date on which coverage begins under another vision Plan, as applicable. However, a person who has elected COBRA continuation coverage and whose new Plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new Plan are satisfied.

(7) The date the Qualified Beneficiary becomes entitled to Medicare benefits.

The first premium must be paid to the Group within 45 days of the election of COBRA continuation coverage. Future premium payments must be paid by the first day of each month.

In accordance with ERISA Section 602(3), premium for a qualified disabled person will be 150% of the single, family, or other applicable rate for the coverage during months 19 through 29 of COBRA continuation coverage. The premium for all other COBRA continuation coverage will not exceed 100% of the rate in effect for the Group during months one through 18, and will not exceed 102% of the rate in effect for the Group during months 19 through 36, if applicable.

If you have any questions about continued vision coverage, the Human Resources Department at your company should be able to assist you.

Wyssta's Liability

In no instance is Wyssta liable for any conduct, including but not limited to tortious conduct, negligence, or wrongful acts or omissions by any service provider or other professional practitioner or their agents or employees in the provision or receipt of health care. In no instance is Wyssta liable for services of facilities that, for any reason, are unavailable to you.

Grievance Procedures

How to Contest a Claim Denial

Urgent Care Situations:

Method of Notification

Notice of an Urgent Care Grievance will be accepted by Wyssta if made by a Subscriber or Covered Dependent, or that person's representative, in writing, or by telephone directed to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

888-838-4875

Resolution Process

If the Urgent Care Grievance cannot be resolved through informal discussions, consultations or conferences during the first 48 hours after Wyssta's receipt of the Urgent Care Grievance, the Subscriber, Covered Dependent, or a designated representative may appear before Wyssta's Grievance Committee to present written or oral information with the right to ask questions before the Grievance Committee.

Time Limitation for Resolution

An Urgent Care Grievance will be resolved, whether informally or by the Grievance Committee, within 72 hours of its receipt by Wyssta.

All Other Claims Denial Situations Not Including Urgent Care:

Denial of a Claim for Benefits

If a Subscriber or Covered Dependent makes a claim for Benefits under this Contract and the claim is denied in whole or in part, the Subscriber or the Covered Dependent, or his/her service provider, will receive written notification within 30 days after Wyssta receives the claim, unless special circumstances require an extension of time for processing. The claims decision will be sent on a form entitled "Explanation of Benefits."

If additional time is necessary for processing a claim for Benefits, Wyssta will notify the Subscriber or the Covered Dependent and his/her service provider of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either the Subscriber or Covered Dependent or his/her service provider did not submit information necessary to make a Benefits determination, the notice of extension will describe the required information. The Subscriber or Covered Dependent, or his/her service provider, will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial

If the Subscriber or Covered Dependent has questions about the denial of his/her claim for Benefits, he/she should contact EyeMed Vision Care, LLC at 866-723-0513. Because most questions about Benefits can be answered informally, Wyssta encourages Subscribers and Covered Dependents to first try to resolve any problem by talking with EyeMed. However, Subscribers and Covered Dependent(s) have the right to file an appeal requesting that Wyssta formally review the Benefits determination.

To file a Grievance or to appeal a Benefits determination, contact Wyssta's Benefit Services Department at 888-838-4875 or mail your request to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

The Subscriber or Covered Dependent should provide the reasons why he/she disagrees with Wyssta's Benefits determination and include any documentation he/she believes supports his/her claim. He/she should include the Subscriber's name, the Covered Dependent's name if applicable, and the Subscriber's Employee Identification Number on all supporting documents.

Resolution Procedure

Wyssta will acknowledge the Grievance or Benefits determination appeal within 5 days of its receipt by Wyssta. Wyssta will attempt to resolve the Grievance or Benefits determination appeal through informal discussions, consultations or conferences. In the event that the Grievance or appeal remains unresolved, the Subscriber or Covered Dependent, or his/her representative, has the right to appear before Wyssta's Grievance Committee to present written or oral information and to question the Grievance Committee. The Committee shall advise the Subscriber, Covered Dependent, or his/her representative of the time and place of the meeting at least 7 calendar days before the meeting.

If the Subscriber or Covered Dependent does not exhaust the appeal procedures described above, and if he/she files a lawsuit against the Group's vision Plan and/or Wyssta seeking payment of Benefits, the court may not permit the Subscriber or Covered Dependent to go forward with his/her lawsuit because he/she failed to utilize Wyssta's grievance/claims appeal procedures. No legal action can be brought against Wyssta more than 3 years after the date of the Grievance Committee's final decision on the review of the Benefits determination.

Time Limitations for Resolution

Wyssta will attempt to resolve all Grievances and Benefit determination appeals within 30 calendar days after receipt by Wyssta. Wyssta will inform the Subscriber or Covered Dependent of its decision in writing. If the appeal is denied in whole or in part, the notice will include the following information:

(a) The specific reason(s) for the denial of the appeal;

(b) The reference to the specific Contract provision(s) on which the denial is based;

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim;

(d) A statement describing any voluntary appeal procedures offered by Wyssta and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

(e) If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;

(f) If the denial of the appeal was based on necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Contract to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

If the Grievance or Benefit determination appeal cannot be resolved within 30 days from receipt by Wyssta, Wyssta will notify the Subscriber, Covered Dependent, or his/her representative in writing that it intends to extend the period of time for resolution an additional 30 days. The notification will state when resolution may be expected and the reasons for the additional time needed.

All Grievances and Benefit determination appeals will be resolved within 60 days from date of receipt by Wyssta.

Wyssta's Grievance Committee will consist of 4 persons: A consultant chosen by Wyssta, a representative of Wyssta management, Wyssta's claim administrator, and a Subscriber in a Wyssta Plan who is not a Wyssta employee.

The Subscriber or Covered Dependent may resolve any Grievance through Wyssta's Grievance procedure outlined previously. The Subscriber or Covered Dependent may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a complaint. The Subscriber or Covered Dependent 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 53707-7573

Or the Subscriber or Covered Dependent can call 800-236-8517 outside of Madison, or 608-266-3585 in Madison and request a complaint form.

Notice of Legal Action

No legal action can be brought against Wyssta until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or Wyssta has denied payment, whichever is earlier.

If you have any questions, please contact our office:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

888-838-4875 or 715-344-6087

Problems with Your Insurance?

If you are having problems with any insurance company or agent, do not hesitate to contact them to resolve your problem. You can contact Wyssta at the following address and phone number:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

888-838-4875

The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To file a complaint, write to:

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

Or you can call 800-236-8517 outside of Madison, or 608-266-3585 in Madison and request a complaint form.

Notes:

Finding a Network Vision Provider

We're proud to work with EyeMed® Vision Care as the network provider for Delta Dental members who are enrolled in either a DeltaVision® plan or in Delta Dental's vision discount program.

The EyeMed® Access and Select networks supporting our members are among the nation's largest provider networks, featuring:

- 1,400 EyeMed access points in Wisconsin.
- 61,000+ EyeMed access points nationwide.
- Popular retail chains: LensCrafters®, Pearle Vision®, JCPenney Optical®, Sears Optical®, Target Optical®, Shopko® Optical Centers, and others.

On the Web

1. Go to **www.deltadentalwi.com** and click the "Provider Search" tab and "Find A Vision Provider" in the drop-down box. Enter your address, city, and state or ZIP code.
2. Provider listings will appear, sorted by distance with network affiliation (EyeMed Access or Select) noted.
3. You can then narrow your search by EyeMed Access or Select providers, change your search radius, or sort your results by name, city or zip code.
4. Your list can be printed, emailed, or saved as a PDF.

By Phone

You can also receive provider information by calling EyeMed.

For EyeMed Access plans call **866-723-0513**.
For EyeMed Select plans call **866-723-0514**.

Your plan type will be listed on your ID card.

DeltaVision is administered by Wyssta Insurance, a Delta Dental of Wisconsin company, in conjunction with EyeMed Vision Care.

DELTA DENTAL®

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Stevens Point Office:
2801 Hoover Road
P.O. Box 828
Stevens Point, WI 54481
Phone: 800-236-3712
Fax: 715-343-7615

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