VISION BENEFIT PLAN SUMMARY

This is a Summary of your Group Vision Program (PROGRAM) prepared for Covered Persons with:

Taylor Corporation (GROUP)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Vision Plan Contract Number 12225696 issued by VSP (PLAN).

IMPORTANT

This booklet is subject to the provisions of the Group Vision Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Note: Receipt of the Summary Plan Description does not mean that you have coverage under this Plan. You must still meet the eligibility requirements as set forth in the Plan.

2016
SUMMARY PLAN DESCRIPTION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

PLAN SPONSOR/GROUP:
Taylor Corporation
1725 Roe Crest Drive, P.O. Box 3728
North Mankato, MN  56002-3728
Telephone: (507) 625-2828

PLAN ADMINISTRATOR/COMPANY:
Taylor Corporation
1725 Roe Crest Drive, P.O. Box 3728
North Mankato, MN  56002-3728
Telephone: (507) 625-2828

AGENT FOR SERVICE OF LEGAL PROCESS:
Taylor Corporation
1725 Roe Crest Drive, P.O. Box 3728
North Mankato, MN  56002-3728
Telephone: (507) 625-2828

PLAN FIDUCIARY:
Taylor Corporation or its authorized delegate(s)

EMPLOYER IDENTIFICATION NUMBER: 41-0852411

EMPLOYER PLAN NUMBER: 501

VSP GROUP NUMBER: 12225696

POLICY YEAR: January 1 – December 31

PLAN BENEFITS INSURED BY:
VSP
3333 Quality Drive
Rancho Cordova, CA 95670
Telephone: (800) 877-7195
TAYLOR CORPORATION
VISION BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to explain the Taylor Corporation Vision Benefit Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please contact your local Human Resources Representative.

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY OF VISION BENEFITS</td>
<td>5</td>
</tr>
<tr>
<td>EXCLUSIONS AND LIMITATIONS OF BENEFITS</td>
<td>7</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>8</td>
</tr>
<tr>
<td>EFFECTIVE DATE OF COVERAGE</td>
<td>9</td>
</tr>
<tr>
<td>ADDING NEW EMPLOYEES</td>
<td>10</td>
</tr>
<tr>
<td>MILITARY LEAVE OF ABSENCE</td>
<td>10</td>
</tr>
<tr>
<td>ADDRESS CHANGES</td>
<td>10</td>
</tr>
<tr>
<td>SPECIAL ENROLLMENT PERIODS</td>
<td>10</td>
</tr>
<tr>
<td>FAMILY STATUS CHANGE</td>
<td>11</td>
</tr>
<tr>
<td>LOSS OF COVERAGE</td>
<td>11</td>
</tr>
<tr>
<td>LOSS OF MEDICAL ASSISTANCE (MEDICAID) OR CHILDREN’S HEALTH</td>
<td>12</td>
</tr>
<tr>
<td>INSURANCE PROGRAM (CHIP)</td>
<td></td>
</tr>
<tr>
<td>ELIGIBILITY FOR PREMIUM ASSISTANCE</td>
<td>12</td>
</tr>
<tr>
<td>ACQUIRING A NEW DEPENDENT</td>
<td>12</td>
</tr>
<tr>
<td>CHANGE IN WORK STATUS THAT IMPACTS ELIGIBILITY FOR BENEFITS</td>
<td>13</td>
</tr>
<tr>
<td>GENETIC INFORMATION NONDISCRIMINATION ACT</td>
<td>13</td>
</tr>
<tr>
<td>TERMINATION OF COVERAGE</td>
<td>13</td>
</tr>
<tr>
<td>UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS</td>
<td>20</td>
</tr>
<tr>
<td>ACT (USERRA)</td>
<td></td>
</tr>
</tbody>
</table>
QUALIFIED EVENTS FOR CONTINUATION OF COVERAGE ........................................ 20
PLAN PAYMENTS ........................................................................................................ 21
APPEAL .......................................................................................................................... 23
GENERAL INFORMATION .............................................................................................. 24
STANDARD PROVISIONS ............................................................................................... 25
PLAN ADMINISTRATION ................................................................................................. 26
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) ...................................... 27
DEFINITIONS .................................................................................................................. 28
SUMMARY OF VISION BENEFITS

Vision Care Coverage, provided through VSP, features a network of independent eye doctors. The Vision Care Coverage offers benefits whether or not you see VSP doctors. But, you will receive a higher benefit when you use a VSP doctor.

Benefits Frequency

*Exams:* Once every Calendar year  
*Lenses:* Once every Calendar year  
*Frames:* Once every other Calendar year  
*Diabetic Eyecare Program:* As Needed  
*Retinal Screening:* Once every Calendar year

*Note:* With single +1 coverage if an employee switches the +1 dependent each year and a dependent uses the frames one year, the next year even though it is a new dependent this benefit is considered to be used. Example: In 2015 employee covers themself and spouse under S+1. The spouse receives frames and lenses in 2015. Then in 2016 the employee covers themself and daughter instead of the spouse, the daughter can get the benefit of the vision exam as well as the benefit of the lenses, but would not get the benefit of the frames as this will not be available for use until 2017 under S+1 coverage.

Copayments:

- $15 Exam
- $20 Frames
- $39 Retinal Screening
- $60 Contact Lens Exam

<table>
<thead>
<tr>
<th>VSP Benefits</th>
<th>VSP Doctor Coverage</th>
<th>Out-of-Network Provider Schedule of Allowances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Vision Exam</td>
<td>100% after $15 copay</td>
<td>Reimbursed up to $50 after $15 copay</td>
</tr>
<tr>
<td>Frames</td>
<td>Covered up to $130 after $20 copay</td>
<td>Reimbursed up to $70 after $20 copay</td>
</tr>
<tr>
<td></td>
<td>$150 allowance for wide selection of frames</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$80 Costco Allowance</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>Including polycarbonate for dependent children</td>
<td>No coverage</td>
</tr>
<tr>
<td>• Single vision</td>
<td>Covered at 100% after $20 Copay</td>
<td>Reimbursed up to $50 allowance.</td>
</tr>
<tr>
<td>• Lined Bifocal</td>
<td>Covered at 100% after $20 Copay</td>
<td>Reimbursed up to $75 allowance.</td>
</tr>
</tbody>
</table>
### Lined Trifocal
- Covered at 100% after $20 Copay
- Reimbursed up to $100 allowance.

### Contact Lenses
#### Exam
- 100% after $60 copay
- No coverage

#### Lenses (In lieu of glasses)
- Up to $150
- Reimbursed up to $105 allowance.

### Retinal Screening
- 100% after $39 copay
- No Coverage

### Diabetic Eyecare Program
- $20 copay
- No coverage

### Laser Vision Correction
- Contact VSP for information on discounts.
- No discounts.

*Note: When deciding on a frame ask the doctor which ones are covered in full. Your plan covers a large selection of the frames on the retail market. You may choose a frame outside the plan coverage and simply pay the difference in cost less 20%.

### Additional Discounts
Each Insured shall be entitled to receive a discount toward the purchases of additional complete pairs of prescription glasses and sunglasses (lenses, lens options and frames). Additionally, each Insured shall be entitled to receive a discount of fifteen percent (15%) off of the VSP Doctor’s professional fees for contact lens examination services. Contact lens materials are provided at the doctor’s usual and customary charges. Discounts are applied to the VSP Doctor’s usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the VSP Doctor who provided the covered eye examination.

### Retail Chain Affiliate Providers
Benefits Coverage under Affiliate Providers is specific to the provider and is subject to change.

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Person should discuss requested services with their provider or contact VSP Customer Care for details.

### Low Vision Benefit
The Low Vision benefit is available to those who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by VSP consultants.

<table>
<thead>
<tr>
<th>VSP Benefits</th>
<th>VSP Doctor Coverage</th>
<th>Out-of-Network Provider Schedule of Allowances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Testing</td>
<td>Covered in full.</td>
<td>Reimbursed up to $125 allowance.</td>
</tr>
</tbody>
</table>
Complete low vision analysis and diagnosis, which includes a comprehensive exam of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

| Supplemental Aids | Covered up to 75% of cost. | Covered up to 75% of cost. |

Subsequent low vision therapy as visually necessary or appropriate.

**Benefit Maximum**
The maximum benefit available is $1,000.00 per insured member (excluding Copayment), every two years.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

This policy is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, there are prenegotiated reduced fees with an average of 35%-40% however you are responsible for the full costs after the discount:

1. Blended lenses.
2. Contact lenses (except as noted elsewhere herein).
3. Oversize lenses.
4. Photochromic lenses;
5. Tinted lenses except pink #1 and pink #2.
7. Anti-reflective coating
8. Color coating.
9. A frame that costs more than the plan allowance.
11. Optional cosmetic processes.
12. UV (ultraviolet) protected lenses.
13. Laminated Lenses
14. Mirror Coating
15. Scratch Coating

Although a low vision benefit is available to Insured’s diagnosed as having severe visual problems (i.e., partial sight), it is subject to limitations. Consult your VSP Doctor or VSP’s Customer Service Department for details.

**There is no benefit for professional services or materials connected with:**
1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.50 diopter power); or two pair of glasses in lieu of bifocals;
2. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
3. Medical or surgical treatment of the eyes;
4. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.
5. An eye examination or any corrective eyewear required by an employer as a condition of employment.

ELIGIBILITY

Eligible Employees
Actives-Employee Eligibility is determined by your Company’s eligibility requirements. For Companies that offer coverage to Full Time employees only, you must be employed at a Full Time (FT) status as defined by your Company. For Companies that offer coverage to Full-Time and Part-time employees, you must be employed at either a Full Time (FT) or Part Time (PT) status as defined by your Company. An employee is eligible the first day of employment at an eligible status. Please contact your Human Resources representative for your company eligible status requirements. To enroll in the Plan, you must elect coverage and you are responsible for the cost of the Plan in accordance with the Plan Administrator’s administrative procedures.

Eligible Dependents
NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent’s coverage, but not both. The company reserves the right to authenticate the marital and dependency status of covered members in the plan at any time during the plan year.

A) Spouse, meaning:
   1. Legally married spouse for purposes of federal law;
   2. Common law opposite gender spouse married as legally recognized in the employee’s state of residence.
   3. Qualified same sex domestic partner of an eligible employee, defined as two unmarried adults of the same sex who have chosen to share their lives in an intimate and committed manner and who, together, each meet all of the following criteria:
      a. Are 18 years of age or older;
      b. Are competent to enter into a contract;
      c. Are not legally married to, nor the same sex domestic partner of, any other person;
      d. Are not related by blood closer than permitted under marriage laws of their state of residence;
      e. Have entered into the same sex domestic partner relationship voluntarily, willingly, and without reservation;
      f. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
         • Living together as a couple and intend to do so permanently;
         • Mutual support of each other;
         • Mutual caring and commitment to each other;
         • Mutual fidelity;
         • Mutual responsibility for each other’s welfare; and
         • Joint responsibility for the necessities in life.
B) Dependent Children

1. Children of the same sex domestic partner of the employee to age 26. NOTE: Children of the same sex domestic partner are eligible only as long as the same sex domestic partner is covered, and they must qualify as a same sex domestic partner’s dependent for Federal tax purposes.


4. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligation of total or partial support.

5. Stepchildren to age 26.

6. Dependent children for whom you or your spouse have been appointed legal guardian to age 26.

7. Foster children to age 26 placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.

8. Grandchildren to age 26 who live with you and are financially dependent upon you.

9. Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

C) Disabled Dependent Children

1. Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:
   a. primarily dependent upon you.
   b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness, or mental disorders;
   c. for whom application for extended coverage as a disabled dependent child is made within 30 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter
   d. must have become disabled prior to reaching limiting age

Coverage will terminate on the last day of the pay period that includes the event date.

**EFFECTIVE DATE OF COVERAGE**

Eligible Employee: You are eligible to be covered under this Plan on the effective date of the Plan or if you are a new employee of the Group, on the first day of employment, provided you enroll on-line through Self Service within 30 days of hire (date of hire is day one). Please contact your supervisor or human resources contact if you do not have a copy of your Company’s current handbook.
Eligible Dependents: Your eligible dependents are covered under this Program on the day your coverage first becomes effective, if dependent coverage is elected.

The amount of benefits payable is subject to all exclusions, limitations and eligibility requirements as defined within this Vision Benefit Plan Summary and the Group Vision Plan Contract between the Group and the Plan.

**ADDING NEW EMPLOYEES**

1. If the Plan Administrator receives your on-line enrollment through Self Service within 30 days of your Enrollment Date, coverage for you and your eligible dependents starts on your date of employment at an eligible status.
2. If the on-line enrollment is completed within Self Service more than 30 days after your Enrollment Date, you are not eligible for coverage. You and your eligible dependents may reapply for coverage at the next annual enrollment unless you meet the requirements of the special enrollment period.

**MILITARY LEAVE OF ABSENCE**

The Uniformed Services Employment and Reemployment Rights Act allows a Participant to take a military leave of absence. The Participant may have the right to have coverage under the health benefits portion of the Plan continued during such leave, for a 24-month period. Upon return from a military leave of absence, the Participant may have a right to reinstate health coverage without any waiting periods. The Participant must request reinstatement within 90 days of the end of the military leave. Please contact the Human Resources Department regarding any required military leave.

**ADDRESS CHANGES**

If you or your dependent’s address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information).

**SPECIAL ENROLLMENT PERIODS**

Special enrollment periods are periods when eligible employees or dependents may enroll in the Plan under certain circumstances after they were first eligible for coverage. The eligible circumstances are 1.) a loss of other group health plan coverage; 2.) loss of Medical Assistance (Medicaid) or Children’s Health Insurance Program (CHIP) coverage; 3.) eligibility for premium assistance under Medicaid or CHIP; 4.) acquiring a new dependent; or 5.) family status change. The request for enrollment must be within 30 days (unless otherwise noted) of the eligible circumstances. The request for enrollment must be made online through Self Service within 30 days of the special enrollment event.
Newborns, newborn grandchildren, children placed for adoption or foster care, and court ordered dependents are eligible as of the date of birth, adoption, placement for adoption or foster care, and court ordered dependents - see Eligible Dependents in the Eligibility section.

FAMILY STATUS CHANGE

A change in family status triggers a special enrollment period in which you can change your level of coverage (for example, single to single + 1) provided the change is consistent with the family status change. The following are examples of changes in family status that trigger the ability to change your level of coverage:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her eligibility for benefits
- Change in dependent status

Please note: If you have a family status change, you must notify the Plan Administrator by making changes online through Self Service within 30 days of the change (date of event is day one). If you miss the 30-day deadline, you will have to wait until the next annual enrollment period.

LOSS OF COVERAGE

Employees or dependents that are eligible but not enrolled in the Plan may enroll for coverage in the Plan as special enrollees upon the loss of other health plan coverage if all of the following conditions are met:

1. the employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. the employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;
3. the employee’s or dependent’s coverage is terminated because his/her COBRA continuation has been exhausted (not due to failure to pay the premium or for cause), he/she is no longer eligible for the plan due to legal separation, divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area.
4. The employee or dependent requested enrollment not later than 30 days after the termination of coverage.

Coverage is effective the day after the termination of prior coverage or the date of claim denial.
LOSS OF MEDICAL ASSISTANCE (MEDICAID) OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE

Employee’s or dependents who are eligible but not enrolled in this Plan may enroll for coverage under this Plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

1. the employee or dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the employee or dependent;
2. the employee must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and
3. the employee or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

ELIGIBILITY FOR PREMIUM ASSISTANCE

Employees or dependents who are eligible, but not enrolled in this Plan, may enroll for coverage under this Plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) if all the following conditions are met:

1. the employer must submit any required documentation indicating that the employee and/or dependents are eligible for premium assistance through Medicaid or CHIP; and;
2. the employee or dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

ACQUIRING A NEW DEPENDENT

Eligible employees who are either enrolled or not enrolled under this Plan may enroll themselves and newly acquired dependents for coverage under this Plan as special enrollees. If the employee is eligible under the terms of the Plan, the employee and eligible dependent are eligible for special enrollment when the employee acquires a new dependent through marriage, birth, adoption or placement for adoption.

Coverage is effective on the date of the marriage, birth, adoption, placement for adoption or foster care and court ordered dependents, if the online enrollment within Self Service is received within 30 days (date of event is day one) after the marriage, birth, adoption, placement for adoption or foster care and court ordered dependents.

Dependent children other than the newly acquired dependent are not eligible for the special enrollment period.
CHANGE IN WORK STATUS THAT IMPACTS ELIGIBILITY FOR BENEFITS

Employees who experience a change in work status that affects their eligibility for benefits may enroll in the Plan as a special enrollee within 30 days (date of event is day one) after the change in status.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Plan will not request, require or otherwise collect genetic information pertaining to you or your family members for the purposes of limiting your benefits or for any other purpose in violation of the Genetic Information Nondiscrimination Act. You should not provide genetic information or family medical history information except when necessary to adjudicate claims. For more information, please contact the Plan Administrator.

TERMINATION OF COVERAGE

Termination Events
Coverage ends on the earliest of the following dates:
1. For you and your dependents, the date on which the Plan terminates.
2. For you and your dependents, on the last day of the pay period that includes:
   a. the date your employment ended,
   b. the date you cease to be eligible,
   c. the date you request coverage be terminated (this is the pay period end that includes the date of the event allowing you to voluntarily drop your coverage),
   d. for the spouse, the date the spouse is no longer eligible for coverage. This is the date on which the employee and spouse divorce or legally separate or the same sex domestic partner no longer meets the same sex domestic partner requirements,
   e. for the dependent child, the date the dependent child is no longer eligible as a dependent under the Plan. This is the date on which:
      1. a covered stepchild is no longer eligible because the employee and spouse divorce.
      2. a covered dependent is no longer eligible because the employee and the same sex domestic partner terminate their same sex domestic partnership.
      3. A covered dependent is no longer eligible because the employee and the same gender spouse terminate their marriage.
      4. the dependent child marries or reaches the dependent-child age limit.
      5. the dependent child becomes eligible for coverage as an employee under any health coverage plan sponsored by the employer.
6. the disabled dependent is no longer eligible.

7. the dependent grandchild is no longer eligible.

3. The date charges are incurred that result in payment up to the Benefit Maximum.

**Prohibition Against Rescission**
The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a participant, unless the participant (or employee who enrolled the participant) commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event:

- a participant fails to timely pay premiums towards the cost of coverage;
- the Plan erroneously covers an ex-spouse of a participant because the participant failed to timely report a divorce to the Plan Administrator;
- the Plan erroneously covers a participant due to a reasonable administrative delay in terminating coverage; or
- any other circumstance under which retroactive termination would not violate the Patient Protection and Affordable Care Act.

A participant shall have the right to appeal a rescission of coverage. In the event the Plan Administrator rescinds a participant’s coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, such rescission shall not cause the individual to incur a “qualifying event” as provided under COBRA.

Note: Employee should enroll in benefits as soon as possible to avoid retroactive premiums. If coverage terminates prior to premium being collected the coverage will not be considered active and employee will not have any coverage or COBRA rights.

**Continuation and Conversion**
You or your covered dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. You and your eligible dependents must be covered under this Plan on the day before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

**Qualifying Events**
If you are the employee and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (including layoff, leave of absence, strike, lockout, change from full-time to part-time employment if it affects benefit eligibility).
If you are the **spouse** of a covered **employee**, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the **employee**.
- A termination of the **employee**'s employment (for reasons other than gross misconduct) or reduction in the **employee**'s hours of employment with the employer.
- Entering of decree in the event of a divorce or legal separation from the **employee**. (This includes if the **employee** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the Plan Administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The **employee** becomes enrolled in Medicare.

In the case of a **dependent child** of a covered **employee**, the **dependent child** has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the **employee**.
- The termination of the **employee**'s employment (for reasons other than gross misconduct) or reduction in the **employee**'s hours of employment with the employer.
- Parents’ divorce or legally separate.
- The **employee** becomes enrolled in Medicare.
- The dependent ceases to be a “dependent child” under the Plan.

**Your Notice Obligations**

You and your dependents must notify the employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A dependent child no longer meets the Plan’s eligibility requirements.

If you or your dependents do not provide this required notice, any dependent that loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependents do not provide this required notice, you or your dependents must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

**Note**: Disability Extensions also require specific notice. See below for these notification requirements.

When you notify the employer of a divorce, legal separation or a loss of dependent status the employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the employer of a qualifying event or disability determination and the employer determines that there is no extension available, the employer will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

**Employer’s and Plan Administrator’s Notice Obligations**

The employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the **employee**. This notice to the Plan Administrator does not occur when the Plan Administrator is the **employer**. After plan administrators are notified of the qualifying event, they have 14 days to send the qualifying event notice. Qualified beneficiaries have 60 days to elect continuation coverage. The 60-day...
time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later.

The employer will also notify you and your dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the employee’s termination of employment (other than for gross misconduct), reduction in hours, death, or the employee’s becoming enrolled in Medicare.

**Election Procedures**

You and your dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.*

You may waive your right to continuation coverage during the 60 day election period. If you do so, you may later revoke your waiver during the same 60 day election period. Revoking your waiver will result in continuation coverage beginning on the day you provide the plan administrator your revocation.

You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, an ex-spouse/spouse may not decline coverage for the other ex-spouse/spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage. In addition, a dependent may elect continuation coverage even if the covered employee does not elect continuation coverage.

**How to Elect**

Contact the employer to determine how to elect continuation coverage.

**Type of Coverage**

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. Anyone who is not covered under the Plan on the day before the qualifying event is generally not entitled to continuation coverage. Exceptions include:

1) when coverage was eliminated in anticipation of a divorce or legal separation the later divorce or legal separation is considered a qualifying event even though the ex-spouse/spouse lost coverage earlier; and
2) a child born to or placed for adoption with the covered employee during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary’s maximum continuation period.

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active employees or their dependents, then continuation coverage will be modified in the same way. Examples: 1) If the employer offers an annual enrollment period that allows active employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation should be allowed to switch plans as well; and 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation should also be afforded this same right.
Maximum Coverage Periods
The maximum duration for continuation coverage is described below. Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of Continuation Coverage Before the End of the Maximum Coverage Period.” In other instances, the maximum coverage period can be extended as described under the heading “Extension of Maximum Coverage Periods.”

18 Months. If you or your dependent loses coverage due to the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the day they lose coverage following termination or reduction in hours.

36 Months. If a dependent loses coverage because of the employee's death, divorce, legal separation, the employee became enrolled in Medicare or because of a loss of dependent status under the Plan, then the maximum coverage period (for spouse and dependent child) is three (3) years from the date of the qualifying event.

Continuation Premiums
Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. All premiums are paid directly to the Plan Administrator.

Extension of Maximum Coverage Periods
Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

- Disability Extension: This extension is applicable when the qualifying event is the employee's termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the employee's termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the employee's termination of employment or reduction of hours.)

Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month following 30 days after a final determination by the SSA that the formerly disabled qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.
Multiple Qualifying Events: This extension is applicable when the initial qualifying event is the employee's termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the employee, divorce, legal separation, the employee becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the employee's dependents who are qualified beneficiaries.

When a second qualifying event that gives rise to a 36-month maximum coverage period for the dependent, the maximum coverage period (for the dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given, no extension of continuation coverage will occur.

Pre-Termination or Pre-Reduction Medicare Enrollment: This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the employee's Medicare enrollment. The extension applies to the employee's dependents that are qualified beneficiaries.

If the qualifying event occurs within 18 months after the employee becomes enrolled in Medicare, regardless of whether the employee's Medicare enrollment is a qualifying event (causing a loss of coverage under the group Plan), the maximum period of continuation for the employee's dependents who are qualified beneficiaries is three (3) years from the date the employee became enrolled in Medicare.

Example: Employee becomes enrolled in Medicare on January 1. Employee's termination of employment is May 15. The employee is entitled to 18 months of continuation from the date coverage is lost. The employee's dependents are entitled to 36 months of continuation from the date the employee is enrolled in Medicare.

If the qualifying event is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

Employer's Bankruptcy: The bankruptcy rule technically is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the Plan, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period
Continuation coverage of the employee and dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary’s continuation coverage is not paid when due.
After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.

After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

If during a 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled.

Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered employees or their dependents whether or not they are on continuation coverage.

Voluntarily canceling your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

Children Born to or Placed for Adoption With the Covered Employee During Continuation Period
A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered employee is a qualified beneficiary and has elected continuation coverage for himself/herself. The child’s continuation coverage begins on the date of birth, adoption, or placement for adoption as outlined in the Eligibility section, and it lasts for as long as continuation coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

Open Enrollment Rights and Special Enrollment Rights
Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. Special enrollment rights will apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes
If your or your dependent’s address changes, you must notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important continuation notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you or your dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled employee or family member is no longer disabled.
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Questions
If you have general questions about continuation of coverage, please contact your Human Resource Representative.

Overview
The following chart is an overview of the information outlined in the previous sections. For more details, refer to the previous sections.

<table>
<thead>
<tr>
<th>Qualifying Event/ Extension</th>
<th>Who May Continue</th>
<th>Maximum Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employment ends (including for reasons other than gross misconduct)</td>
<td>Employee and dependents</td>
<td>Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.</td>
</tr>
<tr>
<td>• Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment if it affects benefit eligibility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Divorce or legal separation</td>
<td>Ex-spouse/spouse and any dependent children who lose coverage</td>
<td>Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Event</td>
<td>Eligible</td>
<td>Earliest of:</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Death of employee</td>
<td>Surviving spouse and dependent children</td>
<td>1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end if the employee had lived.</td>
</tr>
<tr>
<td>Dependent child loses eligibility</td>
<td>Dependent child</td>
<td>Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Dependants lose eligibility due to the employee’s enrollment in Medicare</td>
<td>All dependents</td>
<td>Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Retirees of the employer filing Chapter 11 bankruptcy</td>
<td>Retiree and Dependants</td>
<td>Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.</td>
</tr>
<tr>
<td>(includes substantial reduction in coverage within one (1) year of filing)</td>
<td></td>
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</tr>
</tbody>
</table>

**Extensions to 18-month maximum continuation period:**

- Disability, as determined by the Social Security Administration, of employee or dependent(s)

**Disabled individual and all other covered family members**

<table>
<thead>
<tr>
<th>Earliest of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 29 months after the employee leaves employment; or 2. Date disability ends; or 3. Date coverage would otherwise end.</td>
</tr>
</tbody>
</table>

**PLAN PAYMENTS**

**Covered Fees**

Under this Program, you are free to go to the doctor of your choice. There will, however, be a difference in the payment amount if your doctor is not a VSP doctor.

To avoid any misunderstanding of benefit payment amounts, ask your doctor about his or her participation status prior to receiving vision care.
Claims Appeal Procedure
As a fully-insured benefit, the payment of claims and your rights to appeal claims denied in whole or in part will be administered by VSP. In general, this claims appeal process will be similar to the process described for your convenience below. For an exact description of the claims appeal process administered by VSP, please refer to your VSP group certificate or contact VSP at:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

Initial Claim
The filing procedures for initial claims are described throughout this summary plan description. Payments are made by the plan only when the covered vision procedures have been completed. VSP reserves the right to reject any and all claims for services or benefits that are filed with it more than one hundred eighty (180) days after completion of services.

Notification to Claimant of Decision
VSP has been designated as the claims administrator. When the vision benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received
- For a pre-service claim, 15 days after the claim is received
- For a post-service claim, 30 days after the claim is received

These time periods may be extended for up to 15 days for a pre-service or post-service claim provided VSP determines that such an extension is necessary due to matters beyond the plan’s control and notifies the claimant before the original deadline. This notice will describe why the extension is necessary. If you do not properly submit all the necessary information for your request for benefits, VSP must notify you and tell you what information is missing. You have 45 days to provide the information needed to process your request for benefits. While VSP is waiting on your additional information, that time period does not count towards the time frame in which VSP must decide your claim.

For an urgent care claim, you can be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice

Failure to Follow Urgent Care or Pre-Service Claims Procedures
If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.
**Notice of Incomplete Urgent Care Claim**
If you (or your authorized representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:
- When the plan receives the requested information or
- The end of the period you were given to provide the information

**Concurrent Care Claim**
At times VSP may approve a course of treatment that is provided over time or for a specific number of treatments. If VSP later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.
If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the claims administrator at least 24 hours before the approved course of treatment will expire. If you do so, VSP will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive notice of VSP’s decision based on whether that request is an urgent care or pre-service claim.

**APPEAL**
If you disagree with a coverage decision or denial, you (or your authorized representative) may request a full review by VSP by sending your written request to VSP at:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Employee ID Number of the VSP Enrollee, the Covered Person’s name and date of birth, the name of the provider of services and the claim number. You must state the reason you are requesting re-evaluation of the claim.

You must submit this request within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. If you want to appeal a decision on benefits, send your appeal to the Plan Administrator (for eligibility claims) or VSP (for benefit claims).

Your appeal will be reviewed. Someone other than the person who made the first decision on your claim must make this review. VSP must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claims administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.
Time Limits on Appeal
After a decision is made concerning your appeal, you will be notified of VSP’s findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal
- For a pre-service claim, 15/30 days after receiving the appeal
- For a post-service claim, 30/60 days after receiving the appeal

Appeal Decision
The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
  - If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
  - If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan’s terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- For an initial claim, a description of the appeal procedures
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review.

Second Level Appeal
If you disagree with VSP’s determination, you may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When you have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (“ERISA”), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U.S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(1)(B), you have the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been documented the claims were not approved in whole or in part, and you disagree with the outcome.

GENERAL INFORMATION

Using Your Vision Program
With this program you do not receive an identification card. Please follow the instructions below to access the benefits.

VSP Doctors
To Locate a VSP doctor, call VSP at (800) 877-7195 or follow the directions below to access VSP’s Online Doctor Directory at www.vsp.com.
Once you've found a doctor, call the office to make an appointment. Provide the following:
- Your name and that you're a VSP member.
- Your VSP member group or employer.
- Your Employee ID number (this is not your social security number).
- Your date of birth.

If you are making an appointment for a dependent, provide the member's name, member's Employee ID number and dependents date of birth.

Your doctor will obtain authorization for services. If you are not eligible, the doctor will notify you.

Keep your scheduled appointment and make any copayments. You are responsible for additional costs from cosmetic options or non-covered services. VSP and your doctor will take care of the rest.

**Services at an Out-of-Network Provider**
When using an out-of-network provider, pay the full amount of the bill. To receive reimbursement (up to the allowable amount), submit your claim to:

VSP
PO Box 385018
Birmingham, AL 35238-0518

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Directions on how to submit a claim as well an online claim form can be found at www.vsp.com. Include the following information with the itemized receipt: employer name, employee name, mailing address, Employee ID number, and patient's name and date of birth.

Note - Most out-of-network requests for reimbursement must be submitted to VSP within six months.

**Cancellation and Renewal**
The Program may be canceled by the Plan only on an anniversary date of the Group Vision Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program.

**STANDARD PROVISIONS**

**Change in Plan Benefits**
The Plan Sponsor reserves the right to modify, suspend or terminate all or any part of the Plan at any time or from time to time. Any such Plan modifications or terminations shall be in writing and shall be executed by a duly authorized representative of Taylor Corporation.
A change in Plan Benefits:
   a) Does not require the consent of you or any beneficiary; and
   b) Must be in writing.

**Authority to Interpret Plan**
With respect to issues not addressed in the provisions of the Plan benefits or where provisions require interpretation or the application of plan provisions to specific factual situations including questions of eligibility for benefits, the Plan Administrator, or other fiduciary designated by the Plan Sponsor, shall have the final authority to use its discretion to make a determination with respect to such issues or such provisions.

**Waiver and Estoppel**
The failure by the Plan Administrator to strictly enforce any of the terms, conditions or provisions of the Plan or any defense in any particular instance or instances shall not be construed or operate as a waiver by the Plan Administrator of any such Plan provision or defense and shall not impair the right of the Plan Administrator to insist upon strict compliance or performance in accordance with the terms and conditions of the Plan. The written terms of this Plan may not be modified by any oral or written representation from the Plan Administrator or its delegates. The Plan Administrator shall not be estopped to deny or limit the coverage or benefits available under the Plan in accordance with the written provisions of the Plan by any action, including written or oral communications, or mistake of fact which suggests the existence of coverage or a level of coverage or benefits which are not available under the Plan to the individual asserting the right to such coverage or benefits.

**PLAN ADMINISTRATION**

The Claims Administrator has the authority to decide claims and thus is the claims fiduciary for the Plan. The Plan Administrator is the administrative fiduciary for the Plan and is responsible for the general administration of the Plan (other than deciding claims) and the duty to carry out its provisions. The Plan Administrator is the Company. The board of directors will perform such duties on behalf of the Company, provided it may delegate such duty or any portion thereof to a governing body (e.g. a committee) or a named person, including employees and agents of the Company, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person.

The insurance plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, 12225696, issued by Vision Service Plan.

**Funding and Source of Contributions**
Plan funds are provided by contributions of employees.

**Procedure to Request Information**
If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) STATEMENT OF RIGHTS

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

a. Examine without charge, at the Plan Administrator’s office and at other specified locations, such as work sites 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 Employee Benefits Security 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 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.

Continue Group Health Plan Coverage

d. Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.

e. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the 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.
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 a federal court. In such a 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.

In addition, if you should disagree with the Plan’s decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in federal court; however, you may not assign, convey, or in any way transfer your right to bring a lawsuit to anyone else. If it should happen that the 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, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits 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 Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Company’s Right To Terminate or Amend the Plan. The Company reserves the right to amend or terminate the Plan at any time and without notice.

No Guarantee of Employment. Participation in this Plan is not a guarantee of employment.

DEFINITIONS

Co-payments Any amounts required to be paid by or on behalf of an Insured for Plan Benefits that are not fully covered.

Enrollee An employee or member of Group who meets the criteria for eligibility of the Policy maintained by your Group Administrator.
Experimental Nature  Procedure or lens that is not used universally or accepted by the vision care profession.

Insured  An Enrollee or Dependent who meets Group’s eligibility coverage under this Policy in order to provide vision care coverage to its enrollees and their eligible dependents.

Out-of-Network Provider  Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with Group to provide vision care services and/or vision care materials to Insured’s of Group.

Plan Benefits  The vision care services and vision care materials which an Insured is entitled to receive by virtue of coverage under the Policy, as defined in the Summary of Vision Benefits.

VSP Doctor  An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with Group to provide vision care services and/or vision care materials on behalf of Insured’s of Group.