

Cornell University Endowed Vision Care Plan

Vision Care Benefits

Summary Plan Description

Amended and Restated Effective January 1, 2020

Table of Contents

1. Introduction
 2. General Vision Plan Information
 3. Names and Addresses
 4. Eligibility and Participation Requirements
 5. Summary of Plan Benefits and Limitations
 6. How the Plan is Administered
 7. Amendment or Termination of the Plan
 8. Statement of ERISA Rights
-

1. INTRODUCTION

Cornell University (the “Employer”) maintains the Cornell University Endowed Colleges Health and Welfare Benefit Plan (the “Cafeteria Plan”), a cafeteria plan under Section 125 of the Internal Revenue Code, for the benefit of its eligible employees and their eligible dependents. One component benefit of the Cafeteria Plan is the Cornell University Endowed Vision Care Plan (the “Vision Plan”). The Employer has selected Davis Vision by MetLife (“Davis Vision”) as your vision care benefits administrator. The Vision Plan, underwritten by MetLife Insurance Company (MLIC), provides coverage for routine eye examinations and eyewear. This Summary Plan Description (the “SPD”) provides you with an overview of only the Vision Plan component of the Cafeteria Plan. Vision Plan benefits are provided pursuant to an insurance policy and certificate (the “Policy”) between the Employer and MetLife Insurance Company (MLIC). This SPD is not intended to give you any substantive rights to benefits that are not already provided in the Policy. If the terms of this SPD conflict with the terms of the Policy, the terms of the Policy will control, unless superseded by applicable law.

2. GENERAL VISION PLAN INFORMATION

- A. **Plan Name:** Cornell University Endowed Vision Care Plan, a component benefit of the Cornell University Endowed Colleges Health and Welfare Benefit Plan
- B. **Plan Year:** The 12-month period beginning January 1 and ending December 31
- C. **Type of Plan:** A group vision care plan (a type of welfare benefits plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), provided under a cafeteria plan under Section 125 of the Internal Revenue Code.
- D. **Plan Identification Number:** 539
- E. **Plan Sponsor’s Employer Identification Number:** 15-0532082
- F. **Effective Date:** The effective date of the Vision Plan is January 1, 2020
- G. **Plan Funding Method:** The Vision Plan is fully insured. Benefits are provided under the Policy between the Employer and MetLife Insurance Company (MLIC). Claims are sent to Davis Vision by MetLife (Davis Vision), which is responsible for paying claims. Davis Vision by MetLife and the Employer share responsibility for administering the Plan. Insurance premiums for employees and their families are paid by employee pre-tax payroll deductions. You can obtain a schedule of the applicable premiums by accessing the benefits flyer, which is available on the Human Resources benefits site, and by logging on to www.MetLife.com/Cornell-vision. You may also contact Davis Vision by MetLife Customer Service at 1- 833-EYE-LIFE (1-833-393-5433). Any refund, rebate, dividend, experience adjustment, or other similar payment under the Policy will be allocated, consistent with the fiduciary

obligations imposed by ERISA, to reimburse Employer for premiums that it has paid.

3. NAMES AND ADDRESSES

A. **Plan Sponsor:**

Cornell University
Benefit Services and Administration, Suite 110, EHOB
Ithaca, NY 14850
607-255-3936

B. **Plan Administrator:**

Cornell University
Benefit Services and Administration, Suite 110, EHOB
Ithaca, NY 14850
607-255-3936

The Plan Administrator may delegate some of its duties. Certain duties have been delegated to Davis Vision by MetLife, such as claims processing.

C. **Designated Agent for Service of Legal Process:**

Service of legal process may be made upon the Employer or Plan Administrator at the address above.

D. **Insurance carrier:**

MetLife Insurance Company (MLIC) [Davis Vision, Inc.]
200 Park Avenue
New York, NY 10166

4. Eligibility and Participation

A. **Definitions:**

Covered Persons: All persons who are eligible for and enrolled under the Vision Plan. Covered Persons include members and their enrolled dependents (Partner and children).

Member: An employee who meets the eligibility requirements as described below, and who enrolls for the benefits provided by the Policy.

Partner: Your spouse or domestic partner:

1. By marriage between two adults; or
2. By a union between two adults having the effect of marriage that is recognized by law in the state where you reside; or
3. By a mutual agreement, recognized by the Employer, between two consenting adults who:
 - a. are not married or legally separated;
 - b. occupy the same residence; and
 - c. share household expenses.

The Employer requires domestic partners to complete a Statement of Domestic Partnership form during the 60-day enrollment period as proof of Partnership.

Coverage for Domestic Partner

- To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership. If you have completed and signed a statement of Domestic Partnership and the statement is acceptable to your employer, you may cover as your dependent the person who is the domestic partner named in your statement.

B. Eligibility: You are eligible to apply for coverage under the Vision Plan if you are a regular hourly employee in the Endowed Colleges who is appointed to work at least 20 hours per week, or a salaried employee (faculty/staff) in the Endowed Colleges who is appointed to work 50% full time equivalent for a period of 6 months or more.

Your dependents, defined as your Partner and children, are also eligible. Children may be covered through December 31 of the year in which their 26th birthday occurs.

C. Enrollment: The Vision Plan does not have a waiting period for enrollment. You may enroll in the Vision Plan 1) upon first being hired in an eligible position, 2) during an open enrollment period, or 3) if you experience a life event corresponding to enrollment. Please refer to the "Life Events" section below for more information on life events.

1) New employees in eligible positions have 60 days from the date of hire to enroll.

2) The open enrollment period is the period established by the Employer during which eligible employees and their eligible dependents have the option to enroll in the Cafeteria Plan or make changes to current Cafeteria Plan coverage elections. The annual open enrollment period will be held during **the fall each year**, with benefit elections becoming effective as of the following **January 1**.

3) If you experience a life event corresponding to enrollment (i.e. marriage), you must enroll within 60 days.

Once you enroll, unless you experience a life event, you cannot stop or change your election until the next annual open enrollment period.

Please refer to the Policy for more information on eligibility and enrollment. You may contact the Plan Administrator for assistance with enrollment.

D. Effective Date of Coverage:

Changes made during the annual open enrollment period will be effective the following January 1. Outside of open enrollment, your benefit elections will become effective on the first day of the pay period after your date of hire or life event. If your date of hire or life event is the first day of the pay period, your effective date is the date of your hire/life event. A newborn child is automatically covered from birth provided the Plan Administrator receives notification within 60 days after the birth of the newborn. A child adopted by you or your Partner, or placed for adoption with, or who is a party in a suit for adoption with you or your Partner, is covered automatically provided the Plan Administrator receives notification:

1. If a newborn within 60 days after the child's birth; or

2. If not a newborn within 60 days after the date of adoption, date of placement for adoption or the date the child becomes a party in a suit for adoption by you or your Partner.

A child required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO) is covered automatically from the date stipulated in the court order or administrative process which satisfies the QMCSO requirements of ERISA. Please notify the Plan Administrator of the QMCSO within 60 days.

You can obtain, without charge, a copy of the Cafeteria Plan procedures governing QMCSO determinations from the Plan Administrator.

E. Life Events: When certain life events occur, you may be allowed to make changes to your elections under the Cafeteria Plan. Life events include:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in your or your dependent's employment status, such as beginning or ending employment, strike,

lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage;

- a significant curtailment in your current option, a significant improvement in an option for which you are not enrolled, a significant increase or decrease in cost for one or more of the options under the Vision Plan or a new benefit option under the Vision Plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You previously did not enroll for Vision Plan coverage for yourself or your dependent because you had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 - loss of eligibility for the other group coverage;
 - termination of employer contributions for the other group coverage; or
 - COBRA Continuation of the other group coverage was exhausted;
- A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
 - you to provide health coverage for your child or dependent foster child; or
 - your spouse, former spouse or other individual to provide coverage for your child or foster child if that other person does in fact provide that coverage;
- You or your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

You will be allowed to make changes to your elections only if those changes are on account of the life event, and correspond with the life event. For example, if you are single and enroll for employee-only coverage during the open enrollment period, but during the course of the plan year you get married, you have experienced a life event that will allow you to enroll your spouse, who is now eligible for coverage, outside of the open enrollment period.

You must notify the Plan Administrator within 60 days of your life event in order to make changes to your elections under the Cafeteria Plan.

F. *USERRA Rights:* If you are a member of the United States armed forces, you may have special rights under the Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

USERRA provides reinstatement rights to certain members of the United States armed forces after active military service. You may be eligible to re-enroll yourself and your Partner and children upon your return to work, even if you have not experienced a life event and it is not an open enrollment period. More information about reinstatement rights can be found in the Policy.

USERRA also provides continuation of coverage rights. If you take a leave from employment for “service in the uniformed services,” as that term is defined in USERRA, and as a consequence your coverage under the Vision Plan ends, you may elect to continue coverage for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that the Employer notify you of your rights, benefits and obligations under USERRA, including instructions on how to elect to continue insurance, the amount and procedure for payment of premium.

The University will discontinue the staff member's insurance under the assumption that the staff member will be covered by TriCare, the military coverage while on active duty. However, any family members will be retained on Cornell's plan for a period of time as described below:

Endowed families will be continued with a University contribution to the premium until the staff member returns to work, terminates his/her employment, or in five years, whichever event occurs first. The staff member's family will be billed for their coverage on a monthly basis.

You will be responsible for payment of the required premium to continue coverage under the Vision Plan. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for vision coverage before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total vision coverage premium.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have coverage under the Vision Plan pursuant to USERRA. Contact the Plan Administrator for more information.

G. Termination Of Coverage:

Your coverage ends on the last day of the pay period in which your employment terminates. You have 60 days to elect COBRA to continue coverage under federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See below for more information on COBRA.

Your coverage will end on the earliest date below:

- The first of the month following the date the Policy is terminated; or
- The day following the date you no longer satisfy the eligibility requirements under the Policy; or
- The last day of the last period for which premiums are paid; or
- The day you report for active duty in the armed forces of the United States or any other country (see the section "USERRA Rights" for more information); or
- The end of any period of continuation; or
- With respect to a Partner or child, the first day of the month following the date of the death of the Member or first day of the month following the date the Partner or child no longer satisfies the eligibility requirements under the Policy; or
- The first day of the month following the date you retire from active service with the Employer.

Termination will not affect a claim for benefits incurred while coverage was in effect.

H. COBRA Rights:

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and other members of your family when group vision coverage would otherwise end. For more information about your rights and obligations under the Vision Plan and under federal law, you may contact the Plan Administrator.

What is Continuation Coverage?

You may have other options available to you when you lose group vision coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group vision plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Vision Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Vision Plan is lost because of the qualifying event.

Under the Vision Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you elect COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time the coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active employees, spouses, or dependent children. This means that if coverage for similarly situated employees, spouses, or dependent children changes, coverage for qualified beneficiaries will likewise change.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Vision Plan because of the following qualifying events:

- Your hours of employment are reduced by a certain amount, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Vision Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced by a certain amount;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Vision Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced by a certain amount;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Vision Plan as a “dependent child.”

During the continuation period, a child of yours that is born, adopted by you, or placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to a qualifying event.

When is COBRA continuation coverage available?

The Vision Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

What COBRA premiums will be due?

A qualified beneficiary is entirely responsible for paying the premiums for COBRA coverage, plus any additional amounts allowed by law. The required payment for each continuation coverage period will be described in the notice that is sent when an individual experiences a qualifying event.

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under this Vision Plan will end. A qualified beneficiary is responsible for making sure that the amount of the first payment is correct.

You will be notified of the amount due for each subsequent coverage period for each qualified beneficiary when coverage is elected.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Each qualified beneficiary will have 60 days to elect to continue coverage. If a qualified beneficiary does not notify the Plan Administrator within the 60-day period of his or her election(s), the option to elect continuation coverage will be lost.

However, if you initially waive COBRA coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election window.

How long does COBRA coverage last?

COBRA continuation coverage generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

How can COBRA coverage be extended?

There are ways in which this 18-month period of COBRA continuation coverage can be extended:

- Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Vision Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must start at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. In order to be eligible for the extension, you must notify the Plan Administrator within 60 days of the latest of (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered employee's coverage initially was or will be lost; or (4) the date the COBRA eligible person is provided the initial COBRA notice or this SPD. Written notice to the Plan Administrator must be received before the end of the initial 18 month period. A copy of the Social Security Administration's determination must be provided to the Plan Administrator. If these

procedures are not followed, there will be no disability extension of COBRA.

Your premiums may increase during the disability extension to your continuation coverage.

A person entitled to COBRA coverage must notify the Plan Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. The Plan reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage ends.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Vision Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Vision Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Vision Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

When does COBRA coverage end?

The continuation coverage will terminate on the earliest of:

- The end of the 18, 29, or 36 month continuation period, as the case may be
- The date of expiration of the last period for which the required payment was made
- The date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent's preexisting condition
- The date your employer ceases to provide any group vision plan for its employees

If you have questions:

Questions concerning your Vision Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

5. Summary of Vision Plan Benefits

A. Definitions:

Allowable Charge: the amount negotiated with an In-Network Provider as full payment for a Covered Expense received or purchased by a Covered Person.

Allowance: a flat dollar amount payable under the Policy towards a Covered Expense from an In-Network Provider. If the Provider's charge is less than the Allowance, the Policy will pay only up to the Provider's charge.

Copayment: the amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. If the Copayment exceeds the Provider's actual cost of service, the Covered Person must pay the lesser of the Copayment or the cost of the service, which will also be referred to as the Copayment.

Covered Expense: a benefit covered under the Policy, as shown in the Schedule of Benefits.

Discount: the percentage that an In-Network Provider has agreed to reduce his or her charge by, for a requested service, Material, or procedure.

Materials: frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

Network: a group of Providers who have entered into a contract with Davis Vision by MetLife to provide eye examinations and/or Materials based on a schedule of fees.

Provider: a practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of their license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the state in which the services are provided.

Reimbursement: a flat dollar amount payable under the Policy towards a Covered Expense from an Out-of-Network Provider. If the Provider's charge is less than the Reimbursement, the Policy will pay only up to the Provider's charge.

B. Schedule of Benefits:

Subject to the terms of the Policy, benefits are payable per Covered Person as shown in the Schedule of Benefits. More information about the Schedule of Benefits can be found below and in the Policy.

A Covered Person may use the Provider of their choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers). The payment of benefits varies depending on the type of Provider chosen.

A current list of In-Network Providers can be obtained by logging onto the Davis Vision member website at www.MetLife.com/Cornell-Vision, or by using the MetLife mobile app which is available for both iOS and Android. You may also contact Davis Vision by MetLife Customer Service at 833-EYE-LIFE (1-833-393-5433 for assistance in locating an In-Network provider.

When services or Materials are received from a Provider who is part of the Network, you are responsible for:

1. The Copayment, if a cash payment is due to the Provider; or
2. If an Allowance is provided - the difference between the Allowance and the Allowable Charge. The Policy will pay the dollar amount of the Allowance or the Allowable Charge, if less. If the Allowable Charge is more than the Allowance an In-Network Provider may bill you for the difference. Most In-Network Providers will offer an additional Discount to help with any overage; or
3. If only a Discount is provided - the difference between the Discounted charge and the Allowable Charge. If the Allowable Charge is less than the Discounted charge the Policy will pay the Allowable Charge. If the Allowable Charge is less than the Discounted charge, an In-Network Provider may bill you for the difference.

Benefits for services or Materials received from a Provider outside of the Network are shown in terms of the dollar amount the Policy will pay you for that service or Material. If you use an Out-of-Network Provider, your total responsibility is the difference between the Reimbursement and the Provider's Actual Charge – the Policy will pay the dollar amount of the Reimbursement for that service or Material, or the Provider's Actual Charge if less. An Out-of-Network Provider may bill you for the difference.

You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "Included" or "Included -- no Copayment".

Benefit	In-network benefit	Out-of-network reimbursement
Exam (once every calendar year)	\$0 copay	Up to \$50 reimbursed
Frames (once every calendar year)		
Provider offering Davis Vision Exclusive Collection of Frames³ Fashion tier Designer tier Premier tier	\$0 copay \$0 copay \$0 copay	N/A
Visionworks Retail locations	Allowance of up to \$200 ¹ toward frames, plus 20% off any overage ²	
Other eye care professionals	Allowance of up to \$150 ¹ toward frames, plus 20% off any overage ²	Up to \$50 reimbursed
Lenses (once every calendar year)		
Lenses Single, bifocal, trifocal, lenticular	\$20 copay	\$40 - \$100 reimbursed
Lens extras Tinting, scratch-resistant coating, kids' polycarbonate, oversize lenses	\$0 copay	N/A
Additional lens extras Progressives, anti-reflective, UV, scratch coatings (up to 50% off)	Fixed copay amounts	N/A
Contact lenses - <i>in lieu of eyeglasses</i> (once every calendar year) ¹		
Contacts from the Davis Vision Exclusive Collection of Contact Lenses³ Disposable Planned replacement	\$0 copay – 4 boxes \$0 copay – 2 boxes	N/A
Visionworks (in-network) Other eye care professionals (in-network or out-of-network)	Allowance of up to \$150 ¹ toward Contacts, plus 15% off any overage ²	
Contact lens fitting fee Davis Vision Exclusive Collection ³ Standard and specialty	\$20 copay 15% discount ²	\$0 reimbursed

1. Allowance must be used in full at time of purchase. 2 Additional discounts not applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions. 3. Exclusive Collection is available at most participating independent provider offices. Exclusive Collection is subject to change. Exclusive Collection is inclusive of select torics and multifocals. *If Vision Plan differences exist between this document and the contract, the contract will prevail.

Add-ons: Lens options and coatings (in-network only)	Member cost (in-network only)
Plastic lenses (all ranges of prescriptions/sizes)	Covered
Oversized lenses	Covered
Tinting of plastic lenses	Covered
Scratch-resistant coating	Covered
Polycarbonate lenses for children	\$0
Polycarbonate lenses for adults	\$30
Ultraviolet coating	\$12
Standard anti-reflective (AR) coating	\$35
Premium AR coating	\$48
Ultra AR coating	\$60
Ultimate AR Coating	\$85
Standard progressive	\$50
Premium progressives (Varilux®, etc.)	\$90
Ultra progressives (digital, freeform styles)	\$140
Ultimate Progressives	\$175
High-index lenses 1.67	\$55
High-index lenses 1.74	\$120
Polarized lenses	\$75
Photochromic lenses (Transitions® Signature™)	\$65
Scratch protection plan (single vision / multifocal)	\$20 / \$40
Laser Surgery Benefit (in-network or out-of-network) (Additional discounts available through QualSight)	\$500 Lifetime Reimbursement per member, in-network or out-of-network

Employee Rates	Monthly	Per Pay Period	
		24 Pay Periods	26 Pay Periods
Employee	\$5.57	\$2.79	\$2.57
Employee + Partner	\$11.13	\$5.57	\$5.14
Employee + Child(ren)	\$11.69	\$5.85	\$5.40
Employee + Family	\$16.28	\$8.14	\$7.51
Rates Effective 1/1/2020 through 12/31/2023			

If you have any questions or concerns regarding the Schedule of Benefits, please contact the Plan Administrator or Davis Vision by MetLife [by MetLife](#) 833-EYE-LIFE (1-833-393-5433) or online at www.MetLife.com/Cornell-Vision.

- C. **Urgent / Emergent Care:** The Vision Plan does not cover urgent or emergent care.
- D. **Exclusions and Limitations:** The Vision Plan includes certain exclusions and limitations that may result in the denial of a claim or a loss or reduction of a benefit. Please read the Policy carefully to understand these limitations. Other situations may also lead to a reduction or limitation (e.g., timeline to file a claim), which are described in the Policy.

6. How the Vision Plan is Administered

- A. **Plan Administration:** The Plan Administrator is the Employer. The administration of the Vision Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Vision Plan is carried out, in accordance with its terms, for the exclusive benefit of Covered Persons without discriminating among them. As the Plan Administrator, the Employer is also responsible for satisfying certain legal requirements under ERISA with respect to the Vision Plan (e.g., distributing SPDs and filing an annual report about the Cafeteria Plan with the federal government). The Plan Administrator has delegated certain duties as described below.
- B. **Plan Operations and Authority of the Benefits Administrator.** The Vision Plan is fully insured. The Vision Plan is administered by both the Employer and Davis Vision by MetLife, as the Employer has delegated certain responsibilities for determinations regarding covered benefits and the amount and manner of the payment of benefits, including the appeal of denied claims, to Davis Vision by MetLife, the benefits administrator for the Plan.
- C. **Claims Procedures:**

In-Network:

Prior approval is required for In-Network covered services. You must contact an In-Network Provider before receiving covered services. Identify yourself as a Davis Vision and Cornell University employee or dependent, then provide the office with your member ID number, name, and date of birth of any covered dependent needing services. The In-Network Provider will verify your eligibility for covered services with Davis Vision before the services take place. The Provider will submit your claim directly to Davis Vision. This procedure facilitates claim processing; however, there is no reduction in benefits if you do not obtain prior approval.

You will be notified of the decision on your In-Network claim no later than 15 days after receipt of your claim. This period may be extended one time for up to 15 days, if it is determined that an extension is necessary due to matters beyond the control of the Vision Plan. In such a case, you will be notified of the circumstances requiring an extension, and the date by which a determination is expected. If the extension is needed because you or your Provider failed to submit information necessary to decide the claim, the extension notice will tell you what information is required, and you will have at least 45 days to provide this information.

Out-of-Network:

When you use an Out-of-Network Provider, you must first pay the Provider at the time of service for the full cost, and then submit a claim to Davis Vision by MetLife for reimbursement up to the Out-of-Network Schedule of Benefits. To obtain a claim form, please visit www.MetLife.com/Cornell-Vision, or call at 833-EYE-LIFE (1-833-393-5433).

Claim forms are also available on the Cornell University microsite at www.MetLife.com/Cornell-vision. Completed claim forms can be mailed to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110. Claims may also be submitted via the mobile app or via the website. All benefits will be paid in United States currency to the Covered Person.

If your claim is denied in whole or in part, you will be notified no later than 30 days after your claim is received, unless it is determined that an extension is necessary due to matters beyond the control of the Vision Plan. In such a case, written notice of the extension will be provided to you within the 30 days after your claim is received, and the extension period will be no more than an additional 15 days. The extension notice will indicate the circumstances requiring an extension, and the date by which a determination is expected. If the extension is needed because you failed to submit information necessary to decide the claim, the extension notice will tell you what information is required, and you will have at least 45 days to provide this information.

D. *Appealing Claims:*

If your claim is wholly or partly denied, your determination notice will include:

- i. Reasons for such denial;
- ii. Reference to specific Vision Plan provisions, rules, guidelines or protocols on which the denial was based;
- iii. A description of any additional material or information needed for you to complete the claim, along with an explanation of why such material or information is needed;
- iv. If the denial is based on a medical necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Vision Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- v. Information concerning your right to request that we review our decision; and
- vi. A description of our review procedures, time limits and notice of your right to bring civil action under Section 502(a) of ERISA.

You may file an appeal verbally or in writing, within 180 days after receipt of an initial adverse determination. As part of this appeal, you may:

- i. Send us written comments;
- ii. Request all non-privileged documents, records, and other information relating to your claim, which will be provided to you free of charge; or
- iii. Provide the administrator with other comments, documents, records, and information or proof in support of your claim. The review of your claim will take into account all such information you provide.

Davis Vision by MetLife will not retaliate or discriminate against you for filing an appeal. The review of your appeal will not take into account the initial benefits denial, and will be conducted by someone who is neither the person who made the initial benefits denial, nor that person's subordinate. If your initial benefits denial was based on a medical judgment, the administrator will identify the healthcare professional who consulted on that decision.

In such a case, an appropriate health care professional will be consulted during the review of your appeal (this consultation will not be held with the same health care professional, if any, who was consulted during your initial benefits review, nor that person's subordinate).

Davis Vision by MetLife generally provides written acknowledgment of each appeal within 15 days of receipt.

If your appeal is based on a denial of a pre-approval for In-Network services, the administrator will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of your appeal.

If your appeal is based on a denial of Out-of-Network claims, the administrator will notify you of the decision on your appeal within a reasonable period of time, but no later than 30 days after receipt of your appeal.

If your appeal is denied, your determination notice will include:

- i. The specific reason for the denial;
- ii. Reference to specific Vision Plan provisions, rules, guidelines, or protocols on which the denial was based;
- iii. A statement that you are entitled to receive, upon request and free of charge, copies of documents, records, and other information relevant to your claim for benefits;
- iv. If the denial is based on a medical necessity or experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Vision Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- v. A statement about voluntary alternative dispute resolutions and
- vi. Notice of your right to bring a civil action under Section 502(a) of ERISA, and instructions for initiating an internal second level review.

Timeliness standards for first level appeals will also apply to second level reviews. A second level determination upon appeal will be considered a final determination, at which time a member may be entitled to file an External Appeal if the decision was adverse (see the "External Appeals" section below for more information). Davis Vision by MetLife will provide instructions on how to initiate this process.

If Davis Vision by MetLife has approved an ongoing course of treatment to be provided over a period of time, any reduction or termination of the course of treatment will be considered an adverse benefit determination. You will be notified of this determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

Refer to the Policy for more details on obtaining pre-authorizations, approvals, utilization review decisions, procedures for filing claims, notification of benefit determinations, grievance procedures for the review and appeal of denied claims, refund of overpayments, subrogation and any other ways that benefits may be forfeited under the Vision Plan.

- E. Please note that certain procedures (e.g., appealing a denied claim) have specific time limits; if you do not take action on time, you may lose certain rights (e.g., the right to file suit in a state or federal court if you fail to appeal a denied claim on time).

External Appeals:

Your Right to an External Appeal

In some cases, you have a right to an external appeal of a denial of coverage. If the Vision Plan has denied coverage on the basis that a service is not medically necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by New York State to conduct these appeals.

In order for you to be eligible for an external appeal, you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Expense under the Vision Plan; and
- In general, you must have received a final adverse determination through the internal appeal process described in the “Appealing Claims” section. But, you can file an external appeal even though you have not received a final adverse determination through the internal appeal process if:
 - The administrator agrees in writing to waive the internal appeal. The administrator is not required to agree to your request to waive the internal appeal; or
 - You file an external appeal at the same time that you apply for an expedited internal appeal; or
 - The administrator fails to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the administrator demonstrates that the violation was for good cause or due to matters beyond the administrator’s control and the violation occurred during an ongoing, good faith exchange of information between you and the administrator).

Your Right to Appeal a Determination that a Service is Not Medically Necessary

If the administrator has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the administrator has denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external appeal above and your attending physician must certify that your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by the Vision Plan; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

1. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Expense (only certain documents will be considered in support of this recommendation – your attending physician should contact New York State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

The External Appeal Process

You have four months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on the administrator's failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

The administrator will provide an external appeal application with the final adverse determination issued through the internal appeal process or the written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-342-3736.

Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the administrator based the denial, the External Appeal Agent will share this information with the administrator in order for the administrator to exercise its right to reconsider the decision. If the administrator chooses to exercise this right, it will have three business days to amend or confirm the decision. Please note that in the case of an expedited external appeal (described below), the administrator does not have a right to reconsider the decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician, or the administrator. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and the administrator by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns the administrator's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, the Vision Plan will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Vision Plan will only cover the cost of services required to provide treatment to you according to the design of the trial. The Vision Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under the Policy for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both you and the Vision Plan. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal Appeal, or the administrator's failure to adhere to claim processing requirements. The administrator has no authority to extend this deadline.

F. *Grievance Procedures*

This grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination. For example, it applies to contractual benefit denials or issues or concerns you have regarding administrative policies or access to Providers.

Filing a Grievance

You can contact the administrator by submitting a written request to the following address:

Davis Vision. by MetLife
Attention: Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

You or your designee has up to 180 calendar days from when you received the decision you want reviewed to file the grievance.

When the administrator receives your grievance, it will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

The administrator keeps all requests and discussions confidential and it will take no discriminatory action because of your issue. The administrator has a process for both standard and expedited grievances, depending on the nature of your inquiry.

Grievance Determination

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. The administrator will decide the grievance and notify you within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your grievance.

Pre-Service Grievances: In writing, within 15 calendar days of receipt of your grievance.
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: In writing, within 30 calendar days of receipt of your grievance.
(A claim for a service or treatment that has already been provided.)

All Other Grievances: In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your grievance.
(That are not in relation to a claim or request for a service or treatment.)

Grievance Appeals

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by submitting a written appeal to:

Davis Vision by MetLife
Attention: Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

You have up to 60 business days from receipt of the grievance determination to file an appeal. If you have completed the appeals process without satisfaction, you may have the right to bring civil action under 502 (a) of ERISA.

When the administrator receives your appeal, it will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. The administrator will decide the appeal and notify you in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of two business days of receipt of all necessary information or 72 hours of receipt of your appeal.

Pre-Service Grievances: 15 calendar days of receipt of your appeal.
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of your appeal.
(A claim for a service or treatment that has already been provided.)

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.) 30 business days of receipt of all necessary information to make a determination.

Assistance

If you remain dissatisfied with the appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Questions: If you have any general questions about the Vision Plan (e.g., whether you are eligible to participate), please contact the Plan Administrator. If you have questions about benefits, the provider network, or general plan benefit information, please contact Davis Vision by MetLife's customer care center at _ or call 833-EYE-LIFE (1-833-393-5433 or visit online at www.MetLife.com/Cornell-Vision.

G. .

7. Amendment or Termination of the Plan

The Employer reserves the right to terminate the Cafeteria Plan or amend or eliminate benefits, including vision benefits, under the Cafeteria Plan at any time in its sole discretion. The Cafeteria Plan and/or the Vision Plan may be amended or terminated by a written instrument duly adopted by the Employer or any of its delegates. Termination of the Policy will not affect a claim for benefits incurred while coverage was in effect.

8. Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Employer's principal office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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 Employer may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Employer, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Partner or children 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 COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds 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 summary of vision care benefits 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 N.W., 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.

9. Plan Privacy Information

Notwithstanding any other provision in this Summary Plan Description or the Vision Plan or Policy, the Vision Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA") with respect to protected health information ("PHI") as that term is defined therein. The Plan Administrator and/or its designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Vision Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Vision Plan.
- Other uses relating to plan administration which are approved in writing by the Plan Administrator or designated privacy officer.
- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Vision Plan.

Uses and Disclosures of PHI by the Vision Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

Sharing of PHI with the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Vision Plan, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Vision Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Vision Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Vision Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Vision Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Vision Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure that adequate separation between the Vision Plan and Plan Sponsor is established in accordance with the following requirements:
 - Employees to be given access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Vision Plan: See HIPAA certification, too many to list.
 - Restriction to Plan administration functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Vision Plan.

- Mechanism for resolving issues of noncompliance: If the Plan Administrator or privacy officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the provisions outlined above, then the Plan Administrator or privacy officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.
- Certify to the Vision Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan documents incorporate the provisions in this Section.

Participants Rights

Participants and their covered dependents will have the rights set forth in the Vision Plan's or its vision insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under HIPAA. The Notice may periodically be revised by the Vision Plan or its vision insurer.

Privacy Complaints/Issues

All complaints or issues raised by Vision Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator or the Vision Plan's appointed privacy officer. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues, this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator or privacy officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator or privacy officer shall be final and be given full deference by all parties.

Security

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Vision Plan, the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Vision Plan;
- Ensure that adequate separation between the Vision Plan and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Vision Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.