

# **YOUR BENEFIT PLAN**

**Mohawk ESV, Inc.**

**All Actively at Work Full-Time and Part-Time Employees  
Who Work 30 Hours or More Per Week**

**Vision Insurance for You and Your Dependents**

**Certificate Date: January 1, 2020**

Mohawk ESV, Inc.  
160 South Industrial Blvd.  
Calhoun, GA 30701

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Mohawk ESV, Inc.



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

## CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

**Policyholder:** Mohawk ESV, Inc.

**Group Policy Number:** 114147-1-G

**Type of Insurance:** Vision Insurance

**MetLife Toll Free Number(s):**  
**For Claim Information** FOR VISION CLAIMS: 1-855-METEYE1

**THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.**

**FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.**

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.**

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.**

**For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.**

**For New Hampshire Residents: 30 Day Right to Examine Certificate.**

Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

## IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-855-METEYE1

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007

Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:**

This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-855-METEYE1

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007

Sitio Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**DISPUTAS POR PRIMAS DE SEGUROS O**

**RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

**ADJUNTE ESTE AVISO A SU CERTIFICADO:**

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

# **NOTICE FOR RESIDENTS OF ALASKA, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON**

## **The Definition Of Child Is Modified For The Coverages Listed Below:**

### **For Alaska Residents (Vision Insurance):**

The term also includes newborns.

### **For Louisiana Residents (Vision Insurance):**

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

### **For Minnesota Residents (Vision Insurance):**

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

### **For Montana Residents (Vision Insurance):**

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

### **For New Hampshire Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

### **For New Mexico Residents (Vision Insurance):**

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied vision insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

### **For Texas Residents (Vision Insurance):**

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

## **NOTICE FOR RESIDENTS OF ALASKA, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON (continued)**

### **For Utah Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Vision plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

### **For Washington Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

# **NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR VISION INSURANCE**

## **Notice Regarding Your Rights and Responsibilities**

### **Rights:**

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of You and the Vision Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Vision Insurance sections of this certificate for more details.
- You may request a written response from MetLife to any written concern or complaint.

### **Responsibilities:**

- You are responsible for the prompt payment of any charges for services performed by the Vision Provider not fully covered by your Vision Insurance.
- You should consult with the Vision Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Vision Provider the most current, complete and accurate information about Your medical and vision history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Vision Provider.



## **NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
(501) 371-2640 or (800) 852-5494

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

### **IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:**

**METROPOLITAN LIFE INSURANCE COMPANY  
ATTN: CONSUMER RELATIONS DEPARTMENT  
500 SCHOOLHOUSE ROAD  
JOHNSTOWN, PA 15904**

**1-800-438-6388**

**IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
CONSUMER SERVICES  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013**

**WEBSITE: <http://www.insurance.ca.gov/>**

**1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

## NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for vision insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

**"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

## **NOTICE FOR RESIDENTS OF IDAHO**

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

# **NOTICE FOR RESIDENTS OF ILLINOIS**

## **IMPORTANT NOTICE**

To make a complaint to MetLife, You may write to:

MetLife  
P.O. Box 997100  
Sacramento, CA 95899-7100

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

**Questions regarding your policy or coverage should be directed to:**

**Metropolitan Life Insurance Company  
1-855-METEYE1**

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi)

## **NOTICE FOR RESIDENTS OF MAINE**

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.



## NOTICE FOR MASSACHUSETTS RESIDENTS

### CONTINUATION OF VISION INSURANCE

1. If Your Vision Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Vision Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Vision Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

**Plant Closing** and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

### CONTINUATION OF VISION INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Vision Insurance for Your former Spouse that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Vision Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Vision Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Vision Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS**

### **CONTINUATION OF YOUR VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all employees;
- this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Vision Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Vision Insurance;
- the amount of premium payment that is required to continue Your Vision Insurance;
- the manner in which You must request to continue Your Vision Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Vision Insurance may include:

- any amount that You contributed for Your Vision Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Vision Insurance, You must:

- send a written request to continue Your Vision Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Vision Insurance; or
- the date You become eligible for coverage under any other group Vision coverage.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)**

### **CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which You belong, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Vision Insurance for Your Dependents ends because You fail to pay a required premium.

If Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Vision Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Vision Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Vision Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Vision Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Vision Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Vision Insurance for Your Dependents may include:

- any amount that You contributed for Your Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Vision Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Vision Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Vision Insurance for Your Dependents will end.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)**

### **CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE (Continued)**

The maximum continuation period will be the longest of the following that applies:

- 36 months if Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Vision Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months with respect to a Dependent Child if Vision Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Vision Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Vision Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

## NOTICE FOR RESIDENTS OF NEW MEXICO

### Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/ConsumerAssistance/index.aspx>.

## **NOTICE FOR RESIDENTS OF PENNSYLVANIA**

Vision Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

## **NOTICE FOR RESIDENTS OF TEXAS**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

# VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

## NOTICE FOR RESIDENTS OF TEXAS

If You reside in Texas, note the following Procedures for Vision Claims will be followed:

### Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

### Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.



## NOTICE FOR RESIDENTS OF UTAH

### Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

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

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o \$500,000 in death benefits
  - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 in hospital, medical and surgical insurance benefits
  - o \$500,000 in long-term care insurance benefits
  - o \$500,000 in disability income insurance benefits
  - o \$500,000 in other types of health insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

# NOTICE TO RESIDENTS OF VIRGINIA

## IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife  
P.O. Box 997100  
Sacramento, CA 95899-7100  
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:  
1-855-METEYE1

If You have any questions regarding an appeal or grievance concerning the vision services that You have been provided that have not been satisfactorily addressed by this Vision Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
1-877-310-6560 - toll-free  
1-804-371-9944 - fax  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

Or:

Office of Licensure and Certification  
Division of Acute Care Services  
Virginia Department of Health  
9960 Mayland Drive  
Suite 401  
Henrico, Virginia 23233-1463  
Phone number: 1-800-955-1819/ local: 804-367-2106  
Fax: (804) 527-4503  
[MCHIP@vdh.virginia.gov](mailto:MCHIP@vdh.virginia.gov)

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

## VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

### Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

### Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for

## **NOTICE TO RESIDENTS OF VIRGINIA (continued)**

the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

## NOTICE FOR RESIDENTS OF WISCONSIN

### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife  
Attn: Corporate Consumer Relations Department  
P.O. Box 997100  
Sacramento, CA 95899-7100  
1-855-METEYE1

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

# TABLE OF CONTENTS

<b>Section</b>	<b>Page</b>
CERTIFICATE FACE PAGE.....	1
NOTICES .....	3
SCHEDULE OF BENEFITS .....	29
DEFINITIONS .....	32
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.....	35
Eligible Classes .....	35
Date You Are Eligible for Insurance .....	35
Enrollment Process For Vision Insurance .....	35
Date Your Insurance Takes Effect .....	35
Date Your Insurance Ends .....	37
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS .....	38
Eligible Classes For Dependent Insurance .....	38
Date You Are Eligible For Dependent Insurance .....	38
Enrollment Process For Dependent Vision Insurance .....	38
Date Vision Insurance Takes Effect For Your Dependents.....	38
Date Your Insurance For Your Dependents Ends.....	40
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.....	41
For Mentally or Physically Handicapped Children.....	41
For Family And Medical Leave .....	41
COBRA Continuation For Vision Insurance .....	41
At The Policyholder's Option .....	42
VISION INSURANCE.....	43
VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS.....	45
VISION INSURANCE: EXCLUSIONS .....	46
VISION INSURANCE: FILING A CLAIM.....	47
VISION INSURANCE: PROCEDURES FOR VISION CLAIMS.....	48
GENERAL PROVISIONS.....	49
Assignment.....	49
Vision Insurance: Who We Will Pay.....	49

## TABLE OF CONTENTS (continued)

<b>Section</b>	<b>Page</b>
Entire Contract.....	49
Incontestability: Statements Made by You .....	49
Conformity with Law .....	49

## SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

### BENEFIT

### BENEFIT AMOUNTS AND HIGHLIGHTS

#### Vision Insurance For You and Your Dependents

Service Interval (months)	Exam	Lenses	Frame	Contacts
	12 months	12 months	24 months	12 months

<b>Exam In-Network Co-Pay</b> <i>Co-payment shall not apply to Retinal Imaging</i>	\$15
<b>Materials In-Network Co-Pay</b> <i>Co-payment shall not apply to Elective Contact Lenses</i>	\$20

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
<b>EYE EXAMINATION (one per frequency)</b>	<b>Covered in full*</b>  Comprehensive examination of visual functions and prescription of corrective eyewear.	<b>Covered up to \$45 allowance</b>  Comprehensive examination of visual functions and prescription of corrective eyewear.	
<b>RETINAL IMAGING</b>	Covered in full with a co-pay not to exceed \$39.  Coverage for retinal imaging is an enhancement to eye examination.  Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
<b>STANDARD CORRECTIVE LENSES</b>	<b>Covered in full after Materials co-pay*</b> Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	\$32 allowance
		Lined Bifocal	\$50 allowance
		Lined Trifocal	\$65 allowance
		Lenticular	\$100 allowance

## SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
<b>STANDARD LENS OPTIONS</b>	Ultra Violet Coating	Covered in full	Applied to the allowance for the applicable corrective lens
	Polycarbonate (child up to age 18)	Covered in full*	
	Scratch Resistant Coating	Covered in full	
	Tints	Covered in full	
	Standard Progressive: \$55 Premium Progressive: \$95 - \$105 Custom Progressive: \$150 - \$175		\$50 allowance
	<p>Polycarbonate (adult): Covered in full with a co-pay not to exceed \$31 for Single Vision and \$35 for Multifocal.</p> <p>Anti-Reflective Coating (variable by type): Single Vision and Multifocal - \$41, \$58, \$69, and \$85.</p> <p>Photochromic - Plastic: Single Vision \$70 and Multifocal \$82.</p>		Applied to the allowance for the applicable corrective lens
<b>FRAMES</b>	<p><b>Covered up to a \$150 allowance</b> Frames are covered to the allowance of \$85 at Costco, Sam's Club and Walmart locations.</p> <p>In-Network Vision Providers prescribe and/or order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.</p> <p>Frames are covered up to the allowance of \$85 at Costco, Sam's Club and Walmart and \$150 at other optical retail locations.</p> <p>You will receive an additional <b>20%</b> savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Sam's Club and Walmart.<sup>1</sup></p>		<b>Covered up to a \$70 allowance</b>
<b>CONTACT LENSES</b>			
<b>FITTING AND EVALUATION</b>	<p><b>Standard and Premium fit:</b> Covered in full</p>		<b>Applied to the allowance for the contact lenses</b>
<b>ELECTIVE</b>	<p><b>Covered up to \$150</b>  Contact lenses are provided in place of lens and frame benefits available herein.</p>		<p><b>Covered up to \$140</b>  Contact lenses are provided in place of lens and frame benefits available herein.</p>



## SCHEDULE OF BENEFITS (continued)

	<b>In-Network Coverage (Using an In-Network Vision Provider)</b>	<b>Out-of-Network Coverage (Using an Out-of-Network Vision Provider)</b>
<b>NECESSARY</b>	<p><b>Covered in full after material Co-payment*</b></p> <p>Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider.</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>	<p><b>Covered up to \$240</b></p> <p>Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider.</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>
<b>SECOND PAIR</b>	<p><b>Lenses: Once every 12 months</b> <b>Frames: Once every 24 months</b></p> <p>This benefit gives you additional eyewear coverage. You can get:</p> <ul style="list-style-type: none"> <li>• Two pairs of prescription eyeglasses; or</li> <li>• One pair of prescription eyeglasses and an allowance toward contact lenses, or</li> <li>• Double your contact lens allowance.</li> </ul>	<p>Same benefits as Standard Frames and Corrective Lenses and/or Contact Lenses for Out-of-Network Coverage.</p>

\* Less any applicable Co-payment.

<sup>1</sup> All lens options are available at participating private practice provider offices, and not to exceed copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. At this time, all lens options and "not to exceed" copays and pricing are not available at Costco and Walmart. Please contact your local Costco and Walmart to confirm the availability of lens options and pricing prior to receiving services.

<b>Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)</b>	
<b>LASER VISION CORRECTION</b>	Savings averaging 15% off the regular price, or 5% off a promotional offer, for laser surgery including PRK, LASIK, and Custom LASIK.
<b>ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES</b>	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements. <sup>2</sup>
<b>ADDITIONAL SAVINGS ON LENS ENHANCEMENTS</b>	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. <sup>2</sup>

<sup>2</sup> These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

## DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a full-time basis or part-time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Anisometropia** means a condition of unequal refractive state of the two eyes, one eye requiring a different lens correction than the other.

**Child** means the following: (for residents of Alaska, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

The definition of Child includes newborns.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide Us notice, a Child also includes a child for whom You must provide Vision Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

**Contributory Insurance** means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Vision Insurance for You and Vision Insurance for Your Dependents.

**Co-Payment or Co-Pay** means a fixed dollar amount for which We are not responsible, as shown in the Schedule of Benefits. You must pay Your Co-Payment at the time services are rendered or materials ordered.

**Covered Person(s)** means an Employee and/or a Dependent covered under this Certificate.

## DEFINITIONS (continued)

**Covered Services and Materials** mean a vision service or materials used to treat Your or Your Dependent's vision condition which is:

- prescribed or performed by a Vision Provider while such person is insured for Vision Insurance;
- Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

**Dependent(s)** means Your Spouse and/or Child.

**Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

**In-Network Vision Provider** means an optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate.

**Keratoconus** means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

**Maximum Benefit Allowance** means the maximum amount We will allow for Covered Services and Materials provided by a Vision Provider.

**Necessary** means Covered Services and Materials that are necessary and meet with professionally recognized standards of practice. The fact that a Vision Provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a Covered Service and Material even though it is listed in the Group Policy or the Benefit Schedule as Covered Service and Material.

**Out-of-Network Vision Provider/Non-Network Vision Provider** means any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

**Plan or Plan Benefits** means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Certificate.

**Progressive Lens** means a multifocal lens that makes the transition from distance to near vision by a gradual, progressive addition of power. The result is a lens with a seamless appearance.

## DEFINITIONS (continued)

**Proof** means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

**Service Interval or Frequency** means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which You or Your Dependent may receive Covered Services and Materials. This period starts on Your or Your Dependent's effective date of coverage. A subsequent service interval starts after vision services or materials are received. Once Covered Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Spouse** means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

**Vision Provider** means an eye care professional who is an optometrist, ophthalmologist, or registered dispensing optician, who:

- Is licensed as such by the proper authorities in the jurisdiction where such services are performed;
- Is acting within the scope of such license.

**We, Us** and **Our** mean MetLife.

**Written** or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Year** or **Yearly**, for Vision Insurance, means the 12 month period that begins January 1.

**You** and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**All Actively at Work full-time and part-time employees of the Policyholder, who work 30 hours or more per week.**

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for the insurance described in this certificate on the later of:

1. January 1, 2020; and
2. the first day of the calendar month following the date You complete the Waiting Period of 60 days.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

### **ENROLLMENT PROCESS FOR VISION INSURANCE**

If You are eligible for insurance, You may enroll for such insurance by completing the Policyholder's enrollment process. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

#### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

### Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

### Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- 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; or
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- 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 Policyholder's plan or a new benefit option under the Policyholder's plan; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- You previously did not enroll for Vision Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- 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; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

- 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.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the date Your employment ends, Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. the date You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS**

### **ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE**

**All Actively at Work full-time and part-time employees of the Policyholder, who work 30 hours or more per week.**

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. January 1, 2020;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the first day of the calendar month following the date You complete the Waiting Period of 60 days.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

### **ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE**

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the Policyholder's enrollment process for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

In order to enroll for Vision Insurance for Your Dependents, You must either (a) already be enrolled for Vision Insurance for You or (b) enroll at the same time for Vision Insurance for You.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Vision Insurance only when You are first eligible, during an enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

### **DATE VISION INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.



## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

### **Enrollment During An Annual Enrollment Period**

During any enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

### **Enrollment Due to a Qualifying Event**

You may enroll for Dependent Insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

### **Qualifying Event** includes:

- 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 change in Your or Your dependent's residence, 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 Policyholder's plan or a new benefit option under the Policyholder's 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;

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

- You previously did not enroll for Vision Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. 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.

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

### **DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS**

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Vision Insurance for You ends;
3. the date the Group Policy ends;
4. the date insurance for Your Dependents ends under the Group Policy;
5. the date insurance for Your Dependents ends for Your class;
6. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent, except the coverage on a Child will cease at the end of the month in which that person ceases to be a Dependent; or
9. the date You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

### **COBRA CONTINUATION FOR VISION INSURANCE**

If Vision Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

## CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

### AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

## **VISION INSURANCE**

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, You may be able to reduce Your out-of-pocket costs by using In-Network Vision Providers because Out-of-Network Vision Providers have not entered into an agreement to limit their charges. You are always free to receive services from any Vision Provider. You do not need any authorization from Us before seeing a Vision Provider.

In-Network Vision Providers have agreed to provide Covered Services and Materials as listed in the SCHEDULE OF BENEFITS.

If You or a Dependent incur a charge for Covered Services and Materials from an Out-of-Network Vision Provider, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

The benefits available under this Vision Insurance are set forth on the SCHEDULE OF BENEFITS. In addition to the Co-Payment, if applicable, You may be responsible for:

- the cost of any services or materials that are not Covered Services and Materials; and
- the cost of any service or material that is in excess of the Maximum Benefit Allowance listed on the SCHEDULE OF BENEFITS.

We do not provide vision services. Whether or not benefits are available for a particular service does not mean You should or should not receive the service. You and Your Vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed.

When requesting Covered Services and Materials from an In-Network Vision Provider, We recommend that You confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-855-METEYE1 or by visiting Our website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

### **PLAN BENEFITS**

We will pay benefits for charges incurred by You or a Dependent for Covered Services and Materials as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If You receive Covered Services and Materials from an In-Network Vision Provider, We will pay the provider directly for all covered benefits.

If You or Your Dependent receive Covered Services and Materials from an Out-of-Network Vision Provider, and You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

#### **In-Network**

If Covered Services and Materials are provided by an In-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS.

If an In-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying:

- the Co-Payment, if applicable; and
- the cost of any service or material that is in excess of the Plan Benefits listed on the SCHEDULE OF BENEFITS.

## **VISION INSURANCE (continued)**

### **Out-of-Network**

If Covered Services and Materials are provided by an Out-of-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS, subject to the Maximum Benefit Allowance.

Out-of-Network Vision Providers may charge You more than the Maximum Benefit Allowance. If an Out-of-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying any amount in excess of the Maximum Benefit Allowance charged by the Out-of-Network Vision Provider.

### **Necessary Contact Lenses**

Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Generally, coverage will be authorized for the following reasons:

- Aphakia—379.31 or 743.35.
- Nystagmus—379.50 through 379.56, 386.11, 386.12 or 386.2.
- Keratoconus—371.60, 371.61, 371.62, 743.41, or 743.42.
- Corneal transplant—V42.5.
- Corneal dystrophies—371.50 through 371.58.
- Anisometropia greater than or equal to 2.00 diopters difference in any meridian based on the spectacle prescription.
- High ametropia greater than or equal to  $\pm 10.00$  diopters in either eye in any meridian based on the spectacle prescription.
- Irregular astigmatism—367.22.

The codes listed above are from the International Classification of Diseases, Ninth Revision, Clinical Modification and are used to describe diseases, injuries, symptoms and conditions. If You have questions about the diagnoses listed above or the codes included with the diagnoses, please contact Your Vision Provider.

### **Coordination of Benefits**

We do not coordinate benefits with any other carrier. If You have coverage with another carrier, please contact that carrier to determine whether coordination of benefits is available.

## VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS

Subject to the Service Intervals and Plan Benefits indicated in the SCHEDULE OF BENEFITS, the following will be Covered Services and Materials:

1. One complete visual examination if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:
  - eyesizes up to and including 60mm;
  - multi-focal lenses in all segment widths;
  - prism and slab off;
  - base curves (regardless of curve);
  - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
  - plastic or glass lenses.
3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age, standard anti-reflective coating, plastic photochromic, polarized premium anti-reflective.
4. Contact lenses.
  - A standard fitting and 1 follow-up visit by a Vision Provider.
  - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.
5. Necessary low vision aids.
6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, You will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.
7. Necessary contact lenses in lieu of all benefits for vision materials.

## VISION INSURANCE: EXCLUSIONS

We will not pay Vision Insurance benefits for charges incurred for:

1. Services and/or materials not specifically included in the SCHEDULE OF BENEFITS as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the SCHEDULE OF BENEFITS.
3. Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
4. Two pairs of glasses instead of bifocals.
5. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical or surgical treatment of the eye.
8. Prescription or non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services or supplies received by You or Your Dependent before the Vision Insurance starts for that person.
14. Missed appointments.
15. Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. Services:
  - for which the employer of the person receiving such services is required to pay by law; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
18. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
19. Services and materials obtained while outside the United States, except for emergency vision care.
20. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.



## **VISION INSURANCE: FILING A CLAIM**

### **CLAIMS FOR VISION INSURANCE**

If you select an In Network Vision Provider, You do not need to file a claim.

If you select an Out-of-Network Vision Provider, You may provide full payment to the Out-of-Network Vision Provider at the time of service and submit the invoice including an itemized statement of charges with Your claim form, or You may be able to assign the claim to the Out-of-Network Vision Provider. If the Out-of-Network Vision Provider accepts the assignment, the provider will submit the claim on your behalf. You will be responsible for any charges not covered by the Plan.

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-855-METEYE1. Vision claim forms can also be downloaded from [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, Your claim will be paid subject to the terms and provisions of this certificate and the Group Policy.

### **CLAIMS FOR VISION INSURANCE BENEFITS**

**When a claimant files a claim for Vision Insurance benefits described in this certificate**, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service.

Claim and Proof may be given to Us by following the steps set forth below:

**Step 1**

A claimant can request a claim form by downloading it from [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

**Step 2**

Complete the claim form as instructed and return it with the invoice.

**Step 3**

The claimant must give Us Proof not later than 180 days from the date of service.

# VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

## Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

### Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

## **GENERAL PROVISIONS**

### **Assignment**

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Vision Insurance benefits to the Vision Provider providing such service.

### **Vision Insurance: Who We Will Pay**

If You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

### **Conformity with Law**

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**

Metropolitan Life Insurance Company  
Metropolitan Tower Life Insurance Company  
SafeGuard Health Plans, Inc.  
Delaware American Life Insurance Company  
MetLife Health Plans, Inc.  
SafeHealth Life Insurance Company

## Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. “Personal information” as used here means anything we know about you personally.

### 1. Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, “you” refers to these individuals.

### 2. Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

### 3. Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

### 4. How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a “consumer report” about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. (“MIB”). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at [www.mib.com](http://www.mib.com).

### 5. Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what

products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

## 6. Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

## 7. HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at [www.MeLife.com](http://www.MeLife.com). For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

## 8. Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

## 9. Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

**Send privacy questions to:**

MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE MOHAWK ESV, INC. VISION INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

## ERISA INFORMATION

### NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Mohawk ESV, Inc.  
160 South Industrial Blvd.  
Calhoun, GA 30701

**EMPLOYER IDENTIFICATION NUMBER:** 20-1880191

PLAN NUMBER	COVERAGE	PLAN NAME
501	Vision Insurance	Mohawk ESV, Inc. Vision Plan

### TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

### AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

### ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

### PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

## **CONTRIBUTIONS TO PREMIUM**

If you enroll for Vision Insurance coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

## **PLAN YEAR**

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

## **CLAIMS INFORMATION**

### **Vision Benefits Claims**

#### **Routine Questions on Vision Insurance Claims**

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

#### **Claim Denial Appeals**

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within



three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

### **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

### **NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE**

COBRA is a federal law that requires most group health plans to give their employees and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Plan for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your vision coverage under This Plan for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Plan for up to 36 months. Also, your covered children may be able to continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan. Group health plans for employers with fewer than 20 employees, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

- a. the end of the 18, 29 or 36 month continuation period, as the case may be;
- b. the date of expiration of the last period for which the required payment was made;
- c. 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;
- d. the date your employer ceases to provide any group health plan for its employees.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Plan. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Employer within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Employee does not make that election. However, covered Employees may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your vision coverage will end. However, if you initially waive COBRA continuation 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 period.

### **Qualifying Event Due To Bankruptcy Of Employer**

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

### **If You Elect COBRA**

If you choose COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time 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 the coverage for similarly situated Employees, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

### **Duration Of COBRA Coverage**

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

**Disability.** If any person entitled to COBRA coverage (the covered Employee, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Employee, covered spouse or covered dependent child must notify the Employer's COBRA 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 a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or
- The last day of the 29th month of total coverage.

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

**Subsequent Qualifying Events.** If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Employee and the spouse divorce, the covered Employee dies, the covered Employee becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Plan, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Employer's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

### **Premiums For COBRA Coverage**

A person entitled to COBRA coverage is entirely responsible for paying the premiums for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

### **Initial Premium Payment**

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 Plan will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

### **STATEMENT OF ERISA RIGHTS**

The following statement is required by federal law and regulation.

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 participants shall be entitled to:

## **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts 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 Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts 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.

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 Vision Plan Insurance**

Continue vision insurance 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 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 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 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 \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; 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 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 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.

## **PLAN PRIVACY INFORMATION**

**Notwithstanding any other Plan provision in this or other sections of this Plan, the 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 his or her 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.**

**The term "Plan Sponsor" means Mohawk ESV, Inc.**

**The term "Plan Administrator" means Mohawk ESV, Inc.**

### **I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor**

The 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 Plan.
- Other uses relating to plan administration which are approved in writing by the Plan Administrator or Privacy Officer.
- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

### **II. Uses and Disclosures of PHI by the 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.

### **III. Sharing of PHI With the Plan Sponsor**

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the 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 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 Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the 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 Plan and Plan Sponsor is established in accordance with the following requirements:

(A) 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 Plan:

**Benefits Administrators, Benefits Coordinators, Director of Employee Benefits Operations, or Employee Benefits Managers.**

(B) 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 Plan.

(C) 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 plan document 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 Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section III.

#### **IV. Participants Rights**

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

#### **V. Privacy Complaints/Issues**

All complaints or issues raised by 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 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.

#### **VI. Security**

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which 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 Plan;
- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with 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 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.

#### **FUTURE OF THE PLAN**

It is hoped that This Plan will be continued indefinitely, but Mohawk ESV, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Mohawk ESV, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

## **Uniformed Services Employment And Reemployment Rights Act**

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

### **Continuation of Group Vision Insurance:**

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 vision insurance coverage under your employer’s group vision insurance policy ends, you may elect to continue vision insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your 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. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. 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 insurance 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 insurance premium, including any amount that your employer was paying before the leave began.

You 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 vision insurance coverage under your employer’s group vision insurance policy pursuant to USERRA. Contact your employer for more information.