ROCHESTER INSTITUTE OF TECHNOLOGY

Vision Care Plan

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RIT reserves the right to modify or terminate all or any portion of the employee benefits package at any time with or without notice. Such changes automatically will apply to you and your employment relationship with RIT. Participation in these plans is provided to eligible employees and does not constitute a guarantee of employment, and requires continued employment and eligibility.

Introduction

The RIT Vision Care Plan is designed to cover much of the cost of prescription eyeglasses and contact lenses. This summary addresses important topics such as eligibility, changing your election, appealing the denial of a claim, and what happens when your coverage ends. In addition, this summary describes the benefit provisions of the Plan, which is a fully-insured plan administered by VSP.

This summary is for regular faculty, regular staff, adjunct faculty, and adjunct staff, as well as retirees, LTD recipients and survivors.

Important Note About Passwords

Password security is critical due to the confidential, private, and financial data that is available online. The employee/participant/covered family member is responsible for maintaining security of their passwords and adhering to RIT information security polices and standards.

General Information

Who is Covered and When

Regular full-time and part-time employees scheduled to work nine or more months are eligible to participate in the plan 12 months per year; regular full-time and part-time employees scheduled to work less than nine months are eligible to participate in the plan when working as an RIT employee. Adjunct employees are eligible to participate in semesters in which they work at RIT. If you elect coverage, it can begin on the first day of the month on or after your date of employment. You need to enroll, however, and authorize the payroll deductions to pay your share of the cost before coverage can begin. If your contribution is too high to be deducted from your pay, we will set you up for billing by our outside billing administrator and you will pay with after-tax dollars. You must enroll within 31 days from your date of hire; otherwise, you cannot enroll until the fall open enrollment, effective January 1 of the following year. If you are not at work on the day coverage is supposed to start, coverage will become effective on the day you return to active employment.

You also may obtain coverage for your spouse or domestic partner and/or eligible children by enrolling in two person or family coverage and authorizing payroll deductions (or billing if your pay is too small) to pay your share of the cost. You may not cover your spouse/domestic partner as a dependent if your spouse is enrolled for coverage as an employee. No child can be covered as both an employee and a dependent.

Please refer to the separate summary on providing benefits for your domestic partner.

The eligibility rules for children are as follows:

- The child of the employee or the employee's spouse who is under age 26.
- The child of the employee's domestic partner who is under age 26 *(NOTE: if the child is not claimed as a dependent on the employee's federal income tax return, this benefit will be taxable).*
- The foster child (under age 18) of the employee, defined as an individual who is placed with the employee by an authorized placement agency or by judgment decree, or other court order.
- Any other child who is under age 26, and
    - for whom the employee is the legal guardian or custodian, and

- who resides in the employee's home, and
- who is claimed as a tax dependent on the employee's federal income tax return.

Coverage for your dependents usually begins when your coverage begins. However, if your spouse/partner or a child is confined in an institution or at home for medical reasons when coverage is supposed to begin, coverage will become effective on the first day the person is no longer confined.

A spouse who is divorced from you is not eligible for coverage under the Plan (except under the provisions of COBRA, as described later in this summary), even if a court orders you to provide coverage for your former spouse. If you have an eligible dependent who is also an RIT employee, he or she may be covered either as an employee or as a dependent, but not both.

Also eligible for coverage under this Plan are those in the following categories, both pre-Medicare and Medicare-eligible, who meet the requirements described later in this summary.

- Retirees and spouse/partner/children
- LTD recipients and spouse/partner/children
- Surviving spouse/partner/children.

Eligibility for Retirement

Eligibility for retirement from RIT is based on multiple factors. Detailed eligibility rules for retirement, that are applicable to all benefit plans that are available to RIT retirees, can be found in the Summary Plan Descriptions (SPDs) for RIT's Group Health Insurance Plan and the RIT Retiree-Only Health Reimbursement Arrangement Plan. These SPDs are available on the RIT Human Resources-Benefits website, or a hard copy is available by request.

Proof of Eligibility for Family Members

RIT has a family member verification (FMV) process to ensure that only those people who are eligible for benefits are covered and that the proper tax status is applied. It is important that RIT and employees are spending money as intended and that required taxes are paid.

The process is a simple one; copies of the eligibility verification documents only need to be provided ***once*** for an individual regardless of future benefit plan enrollments (e.g., if you cover your spouse only under dental and later add your spouse to your vision coverage, you will not need to provide another copy of the verification document).

Generally, the approved documents are a marriage certificate for a spouse, a birth certificate for a child, and an affidavit for your eligible domestic partner; refer to the benefits page of the HR website for more details on accepted documents. Copies of verification documents should be provided as follows:

New hires: a new employee must provide the eligibility verification documents before family members can be added to the various benefits coverage.

Mid-Year Changes: generally, the employee must provide the eligibility verification documents before family members can be added to the various benefits coverage. In the case where the document is not available (e.g., birth certificate for a new baby), the family member will be added to the coverage but the employee must provide the required proof within 30 days; otherwise, coverage will be cancelled for the family member.

Open Enrollment Changes: the employee must provide eligibility verification documents by the end of the open enrollment period for any family members added to the coverage. If the documentation is not provided, the

open enrollment change will not be processed and the family member will not be added to the coverage effective January 1.

You Need to Enroll

Vision Care Plan coverage is not automatic; you need to complete an enrollment form for coverage to take effect. On the form you indicate your election of vision care coverage, and whether you want individual, two person, or family coverage.

It is important for you to return the completed enrollment form within 31 days after you first become eligible for coverage. If you wait beyond 31 days to enroll, you will not have another opportunity to enroll until the Plan's next open enrollment.

You may have a different level of coverage than you do for your medical and/or dental coverage (e.g., you can have family medical and two person vision care).

Open Enrollment

Because vision coverage needs change from time to time, you have the opportunity once each year – effective as of January 1 - to make a change in your Vision Care Plan election. You can enroll in or cancel coverage or change your coverage level (e.g., change from individual to two person). Open enrollment changes are completed online through Oracle Employee Self-Service. If you do *not* make a change during an open enrollment period, you will have to wait until the next open enrollment period to make a change unless you experience a qualified change in status, described in the next section. You will find more details in the *Mid-Year Benefits Enrollment Change Summary* in the Other Resources section of the benefits website.

Election Changes During the Plan Year

In general, once you have enrolled in the Plan, you cannot change your coverage level or cancel coverage until the beginning of the next plan year. However, pursuant to federal regulations, you may be able to make mid-year election changes if you meet certain criteria, as explained in items below. Your requested election change must be consistent with the reason for the change, as defined by the Internal Revenue Service. For example, it would be consistent for an employee with two-person coverage that adopts a child during the year to change his or her election to family coverage. It would not be consistent to move from a family contract to a single contract. Changes must be made within 31 days of the event that gives you the right to make a new election. The Plan Administrator may require you to submit certain documentation related to your reason for making a mid-year election change. New elections will become effective on the qualifying event date.

Your benefit elections may be changed – consistent with the event - to reflect the following events:

1. *Qualified Change in Status*
   The following events constitute a qualified change in status:
   - a change in legal marital status: for example, a marriage or divorce
   - a change in the number of dependents: for example, the birth of a child, an adoption, a death, and so on
   - a change in a dependent's eligibility: for example, a child reaches the maximum age under a medical plan

2. *Change in Employment Status*
   The following events constitute a change in employment status where they affect you or your spouse or child:
   - termination of employment
   - commencement of employment
   - commencement or return from an unpaid leave of absence
   - change in employment classification that makes the person either eligible or ineligible to participate in a plan (for example, a change from full-time to part-time status, or the reverse, if such a change affects one's eligibility to participate in a plan).

3. *Changes in Employee's Cost of Coverage*
   With respect to your pre-tax premium contributions, you are permitted to make a mid-year election change if there is a significant increase in the cost of the plan. If there is an ordinary increase or decrease in premiums, your payroll deductions will be automatically adjusted to reflect this change. Any determination of what constitutes a "significant increase" will be made by RIT.

4. *Changes in Coverage*
   If the coverage provided by the plan is significantly curtailed, you may revoke your prior election with regard to the plan.

5. *Qualified Medical Child Support Orders (QMCSO)*
   If a court ordered judgment requires you to provide health care coverage for a child or foster child, or if the order requires someone else to provide coverage, which you were previously providing, you may make mid-year election changes consistent with the QMCSO.

Who Pays For This Protection

This is a voluntary plan, with the employee paying the full premium. The premium contribution is usually deducted on a pre-tax basis. However, if your contribution is too high to be deducted from your pay, we will set you up for billing by our outside billing administrator and you will pay with after-tax dollars. Your cost will be based on whether you choose individual, two person or family coverage. Eligible Retirees and Survivors are billed by our outside billing administrator. LTD recipients will have their contribution amount deducted from the insurance company's LTD benefit payment unless the deduction is higher than the payment; if that occurs, LTD recipients will be billed monthly by our outside billing administrator. All payments are made on an after-tax basis

Refer to the separate contribution summaries for the employee contribution amounts and retiree/LTD/survivor contribution amounts. These rates are subject to change.

Recovery of Overpayments

If any benefit is paid in error to you or a provider, the Plan has the right to recover the amount overpaid. You, your dependent or legal representative shall, on request, provide the Plan with information, sign any documents, make repayment, and do whatever else the Plan says is necessary to recover an overpayment. Any failure to cooperate may result in the Plan's seeking reimbursement directly from you, your dependent or your estate, through legal action.

Coordination of Benefits

If you have vision care coverage under another group plan in addition to this one - through that of a spouse/partner, for example - the total benefits you are eligible to receive could be greater than your actual

expenses. To help eliminate this duplicate spending, our Plan's coverage is coordinated with other group plans with which you have coverage. This means that when the RIT Plan pays second, benefits will be adjusted so that the total payments from both plans won't be more than 100% of total covered charges.

For your own claims and those of your spouse/partner, the plan that pays first is the one that covers you, your spouse or partner as an employee. If your children are covered by more than one plan, the plan of the parent whose birthday occurs earlier in the year will pay benefits first. However, if you are separated or divorced, the plan of the parent who has financial responsibility for the child's health care expenses will pay first. If there is no court decree for health care coverage, then the plan of the parent who has custody of the child will pay first. Where none of these situations apply, the plan that you're covered under the longest will pay first.

What the Vision Care Plan Covers

Benefits are available under this plan if you receive services from a participating provider. You can find VSP providers on their website at www.vsp.com or by calling them at (800) 877-7195/v and (800) 428-4833/TTY Monday – Friday 8 a.m. to 10 p.m., Eastern Time. You can print a Member ID card from the VSP website.

You will not receive an ID card from VSP. And, when you go to a VSP provider, you simply let them know you are a VSP member and they will take care of the rest (no claim forms to file). The ID number will be your RIT University ID (UID) number.

If you or a covered family member receives coverage from a non-VSP provider, you should pay the provider's full fee at the time of service and then submit an itemized bill to VSP for reimbursement according to the schedule of allowances. Discounts do not apply for vision care benefits obtained from non-VSP Providers, so your cost is likely to be higher if you receive services from a non-VSP Provider.
If you go to a VSP provider, the coverage is as follows:

Eye Exam: A routine eye exam is covered once per calendar year with a $15 copay. A diabetic eye exam has a $20 copay (see details below about the VSP Diabetic Eyecare Plus Program℠.

Lenses: VSP's standard lenses are covered in full, every calendar year, after a $20 copay, including glass or plastic single vision, bifocal, trifocal, progressive, or other more complex lenses necessary for the patient's visual welfare. There is an additional cost for various coatings (e.g., anti-reflective, scratch, etc.), but VSP does provide a discount on these optional items.

Frames: $150 allowance toward frames, every calendar year. If you select a frame that costs more than $150, VSP offers a 20% discount off the amount over the retail allowance. Some frames qualify for a $170 featured frame brands allowance.

Contact Lenses: You may choose contacts instead of glasses (lenses and frame). There is a $150 allowance applied to the contact lens exam (fitting & evaluation) and the contact lenses. You also receive a 15% discount off the contact lens exam before the allowance is applied.

Some important notes:

- You can enroll in the RIT Vision Care Plan whether or not you have RIT medical coverage – they are two separate enrollments; you can have the Vision Care Plan without having RIT's medical coverage;
- If you have RIT medical coverage, your coverage level under the RIT Vision Care Plan can be different (e.g., you can have family medical coverage and two person Vision Care coverage); this gives you flexibility if some family members don't wear glasses. However, the employee needs to be covered under the Vision Care Plan in order to cover other family members.

VSP Diabetic Eyecare Plus Program℠

The VSP Diabetic Eyecare Plus Program℠ provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best. A summary of the coverage is as follows:

- The VSP Diabetic Eyecare Plus Program℠ provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or AMD, including:
    - medical follow-up exams,
    - visual field and acuity tests,
    - specialized screenings and diagnostic tests,
    - diagnostic imaging of the retina and optic nerve,
    - retinal screening for eligible members with diabetes.

- The program also provides supplemental[1] coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema.

- Members can self-refer[2], visit their VSP Provider as often as needed, and pay only a copay for services.

[1] The VSP Diabetic Eyecare Plus Program pays secondary to other medical eye insurance coverage.
[2] Unless referral by a primary care physician is required by the health plan.

Low Vision Coverage

Low Vision Services are a plan benefit when specific benefit criteria are satisfied and when prescribed by the covered person's VSP Preferred Provider. Professional services for severe visual problems not correctable with regular lenses are covered as follows:

Supplemental Test: Covered in full*

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1,000*

*maximum benefit for all Low Vision services and materials is $1,000 every two (2) years and a maximum of two supplemental tests within a two-year period.

Exclusions and Limitations of Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. You may obtain details regarding frame availability from the VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic materials. If you or a covered family member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating

- Mirror coating
- Scratch coating
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Not Covered

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a ±.50 diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan that are lost or broken, except at the normal intervals when services are otherwise available
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes
- Local, state and/or federal taxes, except where VSP is required by law to pay
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology
- Corrective vision treatment of an experimental nature, unless approved by an external appeal agent
- Plano contact lenses to change eye color cosmetically
- Artistically-painted contact lenses
- Contact lens insurance policies or service contracts
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing, or cleaning
- Costs for services and/or materials above Plan Benefit allowances
- Services or materials of a cosmetic nature
- Services and/or materials not indicated on this Schedule as covered Plan Benefits

Liability in Event of Non-Payment

In the event VSP fails to pay a VSP preferred provider, you will not be held liable for any sums owed by VSP other than those not covered by the plan.

Vision Coverage in Retirement

Eligibility for retirement from RIT is based on multiple factors. Detailed eligibility rules for retirement, that are applicable to all benefit plans that are available to RIT retirees, can be found in the Summary Plan Descriptions for RIT's Group Health Insurance Plan and the RIT Retiree-Only Health Reimbursement Arrangement Plan.

If you are eligible for RIT retirement, you and your eligible family members are eligible to continue coverage under the Vision Care Plan and you will pay the full premium for the coverage. Refer to the information earlier in this summary which describes eligible family members and cost sharing.

Vision Coverage When Approved for RIT Long-Term Disability (LTD)

Regular full-time employees who are approved for long-term disability by RIT's insurance company are eligible for vision care coverage under this plan as outlined below. Refer to the information earlier in this summary which describes eligible family members and cost sharing.

If your LTD effective date is prior to January 1, 2019, coverage will continue while approved for LTD. Coverage under this plan will end when RIT's LTD insurance company determines that you are no longer eligible for LTD if you were not eligible for retirement from RIT on your LTD effective date.

When your LTD ends and you were eligible for RIT retirement on your LTD effective date, you and your eligible family members would be eligible to continue coverage under this plan under the retiree rules described above.

If your LTD effective date is in 2019 or after, coverage will continue while approved for LTD for up to two years from the LTD effective date. Coverage under this plan will end before two years has elapsed when RIT's LTD insurance company determines that you are no longer eligible for LTD if you were not eligible for retirement from RIT on your LTD effective date.

When you reach the two year benefits continuation maximum and you were eligible for RIT retirement on your LTD effective date, you and your eligible family members would be eligible to continue coverage under the retiree rules described above.

If your LTD ends before the two year benefit continuation maximum and you were eligible for RIT retirement on your LTD effective date, you and your eligible family members would be eligible to continue coverage under the retiree rules described above.

When You Die While You and/or Your Family Members are Covered Under This Plan

Coverage continuation for your eligible survivors is based on multiple factors and is described below.

Upon Your Death if You are Retired or an Employee or LTD Recipient Who is Eligible to Retire

If you are retired at the time of your death, RIT continues coverage for your spouse/partner (who was your spouse or partner at the time of your retirement from RIT) and any eligible child (who was your eligible child at the time of your retirement from RIT) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements.

If you die while employed at RIT and are retirement-eligible at the time of your death, RIT continues coverage for your spouse/partner (who was your spouse or partner at the time of your death) and any eligible child (who was your eligible child at the time of your death) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements.

If you die while on RIT long-term disability (LTD) and you were retirement-eligible at the time your LTD was effective, RIT continues coverage for your spouse/partner (who was your spouse or partner at the time of your death) and any eligible child (who was your eligible child at the time of your death) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements.

Upon Your Death if You are Not Eligible to Retire
The following rules are in effect for the death of an individual who was not retirement eligible:

If you die while employed at RIT and are not retirement eligible at the time of your death, your eligible family members will be offered continuation of coverage under COBRA. If COBRA is elected, RIT will subsidize the COBRA premium for the first six months so the survivor is paying the same amount the employee would have paid for the same level of coverage.

If you die while on RIT long-term disability (LTD) and were not retirement-eligible at the time your LTD was effective, your eligible family members will be offered continuation of coverage under COBRA. If COBRA is elected, RIT will subsidize the COBRA premium for the first six months so the survivor is paying the same amount the employee would have paid for the same level of coverage.

Refer to the section in this summary titled "When You are Eligible for COBRA."

Cancelling Coverage for Non-Payment

RIT's outside administrator, Lifetime Benefit Solutions (LBS), bills employees who are on an unpaid leave of absence or whose pay is too small to take payroll deductions, LTD recipients whose LTD payment is too small to take the deduction, and retirees/spouses/partners/survivors, for the applicable contributions.

There is a grace period before coverage is cancelled for non-payment. If LBS does not receive the full premium amount by the last day of the second month, coverage will be cancelled as of the last day of the second month. For example:

March 11	LBS issues bill for April coverage
April 1	Payment is due for April coverage
April 5	LBS sends a reminder notice for April coverage if not paid
April 11	LBS issues bill for May coverage; bill includes April premium if not paid
May 1	Payment is due for May coverage
May 31	Coverage is cancelled effective May 31 if payment for April coverage is not received

The first time coverage is cancelled for non-payment, there is a three-month waiting period before you can re-enroll in coverage; coverage will not be retroactive. Before you can re-enroll, you must pay the outstanding balance owed as well as the premium for the first month's coverage. Payment must be with a cashier's or bank check, electronic funds transfer (EFT) from your bank account, money order, or credit card.

If coverage is cancelled again for non-payment, there is a six-month waiting period before you can re-enroll in coverage; coverage will not be retroactive. Before you can re-enroll, you must pay the outstanding balance owed as well as the premium for the first month's coverage. Payment must be with a cashier's or bank check, electronic funds transfer (EFT) from your bank account, money order, or credit card.

When Coverage Ends

Your employee vision care coverage under this plan ends the last day of the month in which

- Your employment ends*;
- You are an adjunct employee and you are not working for RIT;
- You are a less than 9-month employee and you are not working for RIT;
- Your employment ends under the RIT Severance Plan (coverage does not continue during the severance period, unless you elect coverage under COBRA);
- You no longer meet the Plan's eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan;
- You stop making required contributions;
- You die; or
- RIT discontinues the Plan.

** Special Note for 9-month faculty:*

- *Coverage will end on June 30 for a faculty member on a 9-month contract, provided that the faculty member works until the end of the contract period, and the contract is not being renewed for the following academic year;*
- *Coverage for a faculty member on a 9-month contract will continue during the summer between the two academic years, provided that the contract is being renewed for the following academic year.*

If you are retired, your vision care coverage under this plan ends the last day of the month

- you stop making required contributions;
- you die; or
- RIT discontinues the Plan.

If you are a long-term disability recipient under RIT's LTD plan and your LTD effective date was before January 1, 2019, your vision care coverage under this plan ends the *earliest of*

- the last day of the month in which your LTD benefits end and you are not retirement eligible;
- you stop making required contributions;
- you die; or
- RIT discontinues the Plan.

If you are a long-term disability recipient under RIT's LTD plan and your LTD effective date was on or after January 1, 2019, your vision care coverage under this plan ends the *earliest of*

- the last day of the month that is two years from the date your LTD became effective;
- the last day of the month in which your LTD benefits end and you are not retirement eligible;
- you stop making required contributions;
- you die;
- RIT discontinues the Plan.

Generally, your dependent's coverage ends when your coverage ends. However, a child's coverage would also end on the last day of the month in which he or she no longer meets the Plan's eligibility.

If you are a surviving spouse/partner/child, your vision care coverage under this plan ends the *earliest of*

- you stop making required contributions;
- you remarry/re-partner (for the spouse/partner);
- you reach the age limit of the plan (for a child);
- you die;
- RIT discontinues the Plan.

If it is determined that you or an eligible family member has submitted a fraudulent claim or fraudulent proof of eligibility, or has intentionally misrepresented any facts under a medical, prescription drug, vision or dental plan, you and all your dependents will be permanently ineligible for coverage under the RIT Medical and Prescription Drug Plan, the RIT Retiree-Only Health Reimbursement Arrangement Plan, the RIT Vision Care Plan, and the RIT Dental Care Plan.

Coverage May Be Continued

In certain circumstances, your coverage and that of your dependents may be continued beyond the date it normally would end. Coverage may continue as shown below, provided you make any required premium contributions.

- For a Disabled Child - Coverage for an unmarried child who is physically or mentally incapable of self-support and who reached age 26 prior to 2019 may be continued beyond the age limit of the plan provided the disability occurred before that age and family coverage under this plan was in effect before the disability occurred. For a child reaching age 26 in 2019 or after, benefits will end the last day of the month in which the child reaches age 26.
- For a Personal Leave of Absence – Coverage may continue while on a personal leave of absence of up to four months. For personal leaves of absence beyond four months, coverage is not continued.
- For a Professional Leave of Absence - Coverage is continued for up to two years while on an approved professional leave of absence, including a sabbatical. For professional leaves of absence beyond two years, coverage is not continued.

When You Are Eligible for COBRA

The following contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This information explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of the coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your eligible children could become qualified beneficiaries if coverage under the Plan is

lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, spouse, or eligible child, you will become a qualified beneficiary if an employee loses coverage. An eligible employee, covered spouse or covered eligible child are entitled to an additional 18 months of coverage under the Plan because one of the following qualifying events happen:

- You no longer meet the Plan's eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan;
- Your approved leave of absence ends (e.g., personal, professional, Family and Medical Leave Act, New York State Paid Family Leave) and you do not return to work; or
- Your approved leave of absence continues, but the maximum benefits continuation period is reached (i.e., coverage ends); or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage. You are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your eligible children will become qualified beneficiaries if they lose coverage. They are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an eligible child.

Note regarding domestic partners and their children: Under federal law, the domestic partner and/or children of a domestic partner are not considered qualified beneficiaries. However, RIT does extend continuing coverage to these individuals as though they were COBRA-eligible.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA administrator of the following qualifying events:

- the end of employment or change in employment or benefits eligibility;
- death of the employee; or
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you must notify RIT Human Resources in writing within 60 days after the qualifying event occurs. The employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice

of the qualifying event should be sent to RIT Human Resources, at the address provided at the end of this summary, and should include the following information:

Request Date (month/day/year)
Employee Name
Employee ID Number
Name of person losing coverage
Relationship to employee
Address for person losing coverage
Reason for loss of coverage (additional documentation may be requested)
Date coverage was lost (month/day/year)

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or the employee becoming ineligible for coverage. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage; these events include the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or an eligible child's losing eligibility as an eligible child.

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

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost

less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Paying for Continuation Coverage
You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium.

For disability extensions up to 29 months if an individual is determined to be disabled (for Social Security disability purposes) Rochester Institute of Technology reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

Grace period for monthly payments
Although monthly payments are due on the first day of each month of COBRA coverage, COBRA participants will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for each month as long as payment is made before the end of the grace period for that payment, but coverage is subject to being suspended as explained below.

If payment is made after the due date but before the end of the 30-day grace period for that month, health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim(s) submitted for reimbursement while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Termination of Continuation Coverage
The law also provides that your continuation coverage may be terminated for any of the following five reasons:

1. Rochester Institute of Technology no longer provides vision coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have Rochester Institute of Technology must limit pre-existing exclusion period to no more than 12 months (18 for a late entrant)). A plan's pre-existing conditions exclusion period will be reduced by each month that you and your family had continuous health coverage (including COBRA continuation coverage) with no break in coverage greater than 63 days. Please note that exclusions and limitations with respect to pre-existing condition requirements have been eliminated for children 19 years of age and under through the Patient Protection and Affordable Care Act (also known as Health Care Reform). Pre-existing conditions exclusions and limitations will no longer apply after 2014;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

If You Have Questions
If you have questions, contact your benefits representative in the Human Resources Department. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA

website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information for return of COBRA Election Forms and Premium Payments:

P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202
Attn: RIT COBRA

Written notice is considered to have been made on the date the notice is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office.

All notices must include: the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Receive a summary of the plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or eligible children if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan of the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-

existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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 in 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the 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 Benefit Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Orders ("QMCSOS")
A medical child support order shall be filed with the plan administrator as soon as reasonably possible after it has been filed promptly upon the receipt of such order, the plan administrator shall notify the participant and each person eligible to receive benefits under the terms of the order ("alternate recipients") of its receipt and of the procedures set forth in this section 14.04.

The Participant and the alternate recipients may provide comments to the Plan Administrator with respect to the order during the 30 day period commencing as of the date the Plan Administrator sends them notice of receipt of the order. The Plan Administrator shall, within the 60 day period commencing as of the expiration of the 30

day comment period specified in the preceding sentence, determine whether the order is qualified and shall so notify the participant and the alternate recipients in writing of its decision. The parties may waive the 30 day comment period. If they do so, the 60 day period shall commence as of the date all parties have waived their rights to submit comments. The Plan Administrator's determination on the qualified status of an order is final. As soon as reasonably practicable following its notification that an order is "qualified," the Plan Administrator shall take such steps it deems appropriate to implement the order.

The Plan Administrator encourages parties to submit draft orders for "pre-approval" of their qualified status prior to their being submitted to a court for signature as such pre-approval will expedite approval procedures.

An alternate recipient may designate a representative for receipt of copies of notices that are sent to an alternate recipient with respect to a medical child support order.

Notice of Privacy Practices

This Notice describes how some of the Rochester Institute of Technology (the "Plan Sponsor") employee benefit plans administered by our carriers, vendors and/or any third-party administrator (collectively referred to in this notice as the "Plan," "we," "us," or "our"), may use and disclose Protected Health Information, as defined below, to carry out payment and health care operations, and for other purposes that are permitted or required by law. The plans covered by these regulations are RIT's Medical Care and Prescription Drug Plan, RIT Retiree-Only Health Reimbursement Arrangement Plan, Dental Care Plan, Vision Care Plan, Beneflex, and Employee Assistance Program (the "Plan").

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under the Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be provided to all participants in the Plan. Copies of RIT's current Notice may be obtained by using the contact information below, or can be found on RIT's HR website at http://www.rit.edu/benefits.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Uses And Disclosures Of Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – We will not use or disclose your PHI for marketing purposes or sell your PHI unless you have signed a written authorization. Additionally, any other uses or disclosures not described in this Notice will be made only after you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that (1) we have taken action in reliance upon the authorization or

(2) the authorization was obtained as a condition of obtaining coverage under the Plan and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – There may be requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, information regarding your medical procedures and treatment may be used to process and pay claims. Your PHI may also be disclosed for the payment of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – Your PHI may be used as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to the Plan.

Treatment – Although the law allows use and disclosure of your PHI for purposes of treatment, as a group health plan, your information generally does not need to be disclosed for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your PHI for purposes of treatment, payment and health care operations.

Family and Friends Involved in Your Care – If you are available and do not object, your PHI may be disclosed to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and it is determined that a limited disclosure is in your best interest, limited PHI may be shared with such individuals. For example, the Plan's claims administrator may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits under the Plan. Examples of these outside persons and organizations might include vendors that process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. Business Associates are also required by law to protect PHI.

Plan Sponsor – PHI may be disclosed to certain employees of the Plan Sponsor for the purpose of administering the Plan. These employees will use or disclose the PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other Uses and Disclosures – There are certain other lawful uses and disclosures of your PHI without your authorization. Disclosures are allowed

- for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence, your PHI may be disclosed to the proper authorities.
- if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- for law enforcement purposes, your PHI may be disclosed to the proper authorities.
- to coroners, medical examiners, and/or funeral directors consistent with law.

- for cadaveric organ, eye or tissue donation.
- for research purposes, but only as permitted by law.
- to avert a serious threat to health or safety.
- if you are a member of the military as required by armed forces services, and for other specialized government functions such as national security or intelligence activities.
- to workers' compensation agencies for your workers' compensation benefit determination.
- if required by law, your PHI will be released to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, uses or disclosure of your PHI will be restricted in accordance with the more stringent standard.

Rights That You Have

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. You have the right to request that we send a copy of your PHI that we maintain in designated record sets to another person. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI or that you want your PHI sent to another person (who must be named in the request), and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that your PHI not be disclosed to your spouse. Your request must describe in detail the restriction you are requesting. Your request will be considered, but in most cases there is no legal obligation to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations and the PHI pertains solely to a health care item or service that you have paid for out-of-pocket and in full. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if

you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to be Notified of a Breach – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

Right to a Copy of the Notice – If you have agreed to accept this Notice electronically, you have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

For Further Information
If you have questions or need further assistance regarding this Notice, you may contact your benefits representative in RIT's Human Resources Department. The mailing address is 8 Lomb Memorial Dr., Rochester, NY 14623.

Complaints and Grievances

You have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. You may submit any complaints and/or grievances, at any time, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than forty-five (45) calendar days after VSP's receipt of all necessary information. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify you of the expected resolution date. Upon final resolution VSP will notify you of the outcome in writing.

If you are not satisfied with the resolution of any complaint and/or grievance, you may file an appeal in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or by calling VSP's Customer Care Division at 1-800-877-7195. You have up to sixty (60) business days from receipt of the complaint and/or grievance determination to file an appeal. VSP will make a determination of an appeal within thirty (30) business days of receipt of all necessary information. If you remain dissatisfied with VSP's appeal determination or at any other time, you may call the New York State Department of Financial Services at 1-800-342-3736 or write them at New York State Department of Financial Services, Consumer Assistance Unit, One Commerce Plaza, Albany, NY 12257.

Claim Payments and Denials

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, the covered person or the covered person's authorized representative may submit a request for a full review of

the denial. The 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: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the covered person affected by the denial. The covered person may review, during normal working hours, any documents held by VSP pertinent to the denial. The covered person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the covered person within thirty (30) calendar days after receipt of a request for an appeal from the covered person.

Second Level Appeal: If the 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. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the covered person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the covered person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When the covered person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. The covered person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. 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, the claims were not approved in whole or in part, and the covered person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the covered person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of anyapplicable statute of limitations, in accordance with the terms of the Policy.

Administrative Claim Procedures

Claims concerning eligibility, participation, contributions, or other aspects of the operation of the Plan should be in writing and directed to the Plan Administrator; this section does not apply to claims for benefits or services under the Plan because all claim decisions are made by the Plan's insurance company, VSP, to whom RIT has delegated this responsibility. The Plan Administrator will generally notify you of its decision within 90 days after it receives your claim.

However, if the Plan Administrator determines that special circumstances require an extension of time to decide your claim, the Plan Administrator may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify you, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If your claim is denied in whole or in part, the Plan Administrator will provide you with a written or electronic notice that explains the reason or reasons for the decision, including specific references to Plan provisions upon which the decision is based, a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information may be necessary), a description of the

appeals procedures and applicable filing deadlines and your right to bring an action under Section 502(a) of ERISA.

If you disagree with the decision reached by the Plan Administrator, you may submit a written appeal to the Plan Administrator requesting a review of the decision. Your written appeal must be submitted within 60 days of receiving the Plan Administrator's decision and should clearly state why you disagree with the Plan Administrator's decision. You may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access to and copies of all documents, records and other information relevant to the claim.

The Plan Administrator will generally decide your appeal within 60 days after it is received. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 60 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify you, in writing and before the end of the initial 60-day period, of the special circumstances requiring the extension and the date by which it expects to render a decision.

The Plan Administrator will provide you with written or electronic notice of its decision. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that you are entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. Additionally, the notice will include a statement regarding your right to bring an action under Section 502(a) of ERISA. Generally, you must exhaust your internal administrative appeal rights before you can bring a legal action against the Plan. The Plan Administrator has full discretionary power to construe and interpret the Plan and its decisions are final and binding on all parties.

Important Information about the Plan

Employer	Rochester Institute of Technology
Employer Identification Number:	16-0743140
Plan Sponsor:	Rochester Institute of Technology 8 Lomb Memorial Drive Rochester, NY 14623 (585) 475-2424
Plan Name:	Vision Care Plan
Plan Number:	514
Plan Year:	January 1 - December 31
Plan Administrator:	Associate Director Human Resources, Benefits Rochester Institute of Technology 8 Lomb Memorial Drive Rochester, NY 14623 (585) 475-2424
Agent for Service of Legal Process:	Office of Legal Affairs Rochester Institute of Technology 154 Lomb Memorial Drive Rochester, New York 14623-5608 Service of legal process may also be made on the Plan Administrator