Amazon and Subsidiaries
Vision Plan
Summary Plan Description

Group Name: Amazon and Subsidiaries
Group Number: 12077753
Effective Date: APRIL 1, 2016

Provided by:
VISION SERVICE PLAN
3333 Quality Drive, Rancho Cordova, CA  95670
Customer Service: 1-800-877-7195
ERISA Plan Identifying Information

The Amazon and Subsidiaries Vision Plan (the “Plan”) is a group health plan subject to the Employee Retirement Income Security Act of 1974 (“ERISA”). This document constitutes the ERISA plan document and summary plan description for the Plan as required under ERISA. It sets forth an explanation, in summary form, of your vision coverage.

Name Of Plan

Amazon and Subsidiaries Vision Plan (a component of the Amazon Corporate LLC Group Health & Welfare Plan)

Name And Address Of Employer Or Plan Sponsor

Amazon Corporate LLC
P.O. Box 81226
440 Terry Ave. N Seattle, WA 98108
(206) 266-1000

You and your dependents may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a participating employer in the Plan and, if so, the participating employer’s address.

Employer Identification Number "EIN"

91-1986545

Plan Number

501

Type Of Plan

Self-funded employee welfare benefit plan that is a group health plan. The Plan provides vision benefits.

Type Of Administration

Third-party administration for claims and certain administrative services.

Name, Address, And Telephone Number Of ERISA Plan Administrator

Amazon Corporate LLC P.O. Box 81226
440 Terry Ave. N Seattle, WA 98108
(206) 266-1000

Agent For Service Of Legal Process

Amazon Corporate LLC P.O. Box 81226
440 Terry Ave. N Seattle, WA 98108
(206) 266-1000

Funding Medium

This plan is self-funded. No benefits are payable by an insurance company.

ERISA Plan Year

The Plan year ends on each March 31st.
<table>
<thead>
<tr>
<th><strong>Definitions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anisometropia</strong></td>
</tr>
<tr>
<td><strong>Benefit Authorization</strong></td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
</tr>
<tr>
<td><strong>Covered Person</strong></td>
</tr>
<tr>
<td><strong>Eligible Dependent</strong></td>
</tr>
<tr>
<td><strong>Emergency Condition</strong></td>
</tr>
<tr>
<td><strong>Employee</strong></td>
</tr>
<tr>
<td><strong>Enrollee</strong></td>
</tr>
<tr>
<td><strong>Experimental Nature</strong></td>
</tr>
<tr>
<td><strong>Group</strong></td>
</tr>
<tr>
<td><strong>Keratoconus</strong></td>
</tr>
<tr>
<td><strong>Member Doctor</strong></td>
</tr>
<tr>
<td><strong>Non-Member Provider</strong></td>
</tr>
<tr>
<td><strong>Plan Benefits</strong></td>
</tr>
<tr>
<td><strong>Related Employer</strong></td>
</tr>
<tr>
<td><strong>Renewal Date</strong></td>
</tr>
</tbody>
</table>
Schedule Of Benefits  The document, attached to this summary plan description, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this Plan.

ELIGIBILITY

Employee Eligibility

Enrolling for coverage and making enrollment elections depend on your employee class and your regularly scheduled work hours per week. For details, see the table “How and When to Enroll” below:

<table>
<thead>
<tr>
<th>How and When to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are…</td>
</tr>
<tr>
<td>A regular full-time Employee (Class F)</td>
</tr>
<tr>
<td>A regular reduced-time Employee (Class R)</td>
</tr>
<tr>
<td>A regular part-time Employee (Class H)</td>
</tr>
<tr>
<td>A regular part-time Class Q Employee (Class Q)</td>
</tr>
</tbody>
</table>

Except as otherwise provided, if you do not elect benefits within the time frames listed above, you will not be eligible to enroll for coverage until the next Open Enrollment period, unless you experience certain limited changes in status.

For existing eligible Employees who elect to participate in the Plan during Open Enrollment, coverage will be effective on the first day of the next plan year, beginning April 1.

Coverage for enrolled Class F, R, and H Employees and their Eligible Dependents who are no longer eligible for the Plan terminates on the last day of the month in which eligibility is lost. Notwithstanding the foregoing, if an Enrollee transfers from one class to a different class with a mid-month effective date, coverage may terminate earlier and/or be limited to the benefits available for one classification only to ensure no duplicate coverage. Coverage for enrolled Class Q Employees who are no longer eligible for the Plan terminates on the Saturday following the Employee’s last day of employment.
Dependent Eligibility

Dependent coverage is only available for family members of eligible Class F, R, and H Employees. Eligible Class Q Employees are not permitted to enroll family members.

To be an Eligible Dependent of a Class F, R, or H Employee under this Plan, the family member must be:

- The lawful spouse of the enrolled Employee, unless legally separated. Lawful spouse means a legal union of two persons that was validly formed in any jurisdiction.
- The domestic partner of the enrolled Employee. Domestic partnerships that are not documented in a state domestic partnership registry must meet all requirements as stated in the signed “Affidavit of Domestic Partnership.” All rights and benefits afforded to a “spouse” under this Plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this Plan, the term “establishment of the domestic partnership” shall be used in place of “marriage”; the term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”
- A child who is under 26 years of age. A “child” is one of the following:
  - A natural offspring of either or both the Employee or spouse.
  - A legally adopted child of either or both the Employee or spouse.
  - A child of a domestic partner
  - A child placed with the Employee for the purpose of legal adoption in accordance with state law. Placed for adoption means assumption and retention by the Employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A legally placed ward of the Employee or spouse. There must be a court order signed by a judge, which grants guardianship of the child to the Employee or spouse as of a specific date. When the court order terminates or expires, the ward is no longer a “child” for purposes of eligibility to participate in this Plan.
  - Grandchildren in the Employee’s court-ordered custody.
  - A foster child.

Coverage may continue beyond age 26 for an Eligible Dependent child who can’t support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching age 26.
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the Employee for support and maintenance.
- The Employee is covered under this Plan.
- The Employee provides proof of the child’s disability and dependent status when requested.

When does coverage begin?

New Hires and Transfers

For more details on when coverage begins, see the table “How and When to Enroll” above.

Class Q Employees may opt out of coverage or opt into coverage under this Plan at any time once they are eligible for the Plan. The change will be effective on the first day of the following month.

Dependents Acquired Through Marriage After the Enrollee’s Effective Date (Does not Apply to Eligible Class Q Employees)

Employees have 60 calendar days starting on the date of marriage to add the Eligible Dependent(s) to the Plan. Plan coverage will become effective as of the date enrolled.

Natural Newborn Children Born On or After the Enrollee’s Effective Date (Does not Apply to Eligible Class Q Employees)

Employees have 60 calendar days starting on the date of birth to add the Eligible Dependent to the Plan. Plan coverage will become effective as of the date of birth.
Adoptive Children Acquired On or After the Enrollee’s Effective Date (Does not Apply to Eligible Class Q Employees)

Employees have 60 calendar days starting on the date of adoption or placement for adoption to add the Eligible Dependent to the Plan. Plan coverage will become effective as of the date of adoption or placement for adoption.

Children Acquired Through Legal Guardianship (Does not Apply to Eligible Class Q Employees)

Employees have 60 calendar days starting on the date of legal guardianship being granted to add the Eligible Dependent to their Plan. Plan coverage will become effective as of the date that legal guardianship is granted.

Children Covered Under Qualified Medical Child Support Orders (Does not Apply to Eligible Class Q Employees)

The Plan extends coverage to an Employee’s non-custodial child, as required by any qualified medical child support order (“QMCSO”) as defined by ERISA Section 609(a). The Plan has procedures for determining whether a court order or National Medical Support Notice qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures by calling the Employee Resource Center at (888) 892-7180.

Events that end coverage

Coverage will end without notice, on the last day of the month, in which one of these events occurs (except as provided elsewhere with respect to Class Q Employees):

- For the Enrollee and his or her Eligible Dependents, when the Enrollee’s employment is terminated, the Enrollee dies or is otherwise no longer eligible for enrollment.
- For a spouse when his or her marriage to the Enrollee is annulled, or when he or she becomes legally separated or divorced from the Enrollee.
- For a child when he or she cannot meet the requirements for dependent coverage shown in the “Dependent Eligibility” section above.

The Enrollee must notify the Group within 60 days when an enrolled family member is no longer eligible to be enrolled as a dependent under this Plan.

Plan Termination

No rights are vested under this Plan. The Group is not required to keep the Plan in force for any length of time. The Group reserves the right to change or terminate this Plan, in whole or in part, at any time without liability. If the Plan were to be terminated, the Enrollee or Eligible Dependent, as applicable, would only have a right to benefits for covered care he or she received before the Plan’s end date.

Intentionally False or Misleading Statements

If an Enrollee or Eligible Dependent provides false information, intentionally misrepresents facts, or engages in fraud against the Plan, the Group has the right to cancel the Enrollee’s and/or Eligible Dependent’s, as applicable, coverage retroactively (i.e., rescind coverage). Enrolling an ineligible individual or otherwise failing to comply with the Plan’s requirements for eligibility will constitute fraud or an intentional misrepresentation of a material fact that will trigger rescission. The Enrollee and/or Eligible Dependent will be liable for all benefits already paid on his or her behalf or on behalf of the ineligible individual, as applicable.

Special Enrollment (Does not Apply to Class Q Employees)

The Plan allows eligible Employees and their Eligible Dependents to enroll outside the Plan’s annual Open Enrollment period only in the cases listed below. These cases are generally known as a qualifying events. In order to be enrolled, the applicant may be required to provide the Group with proof that such an event has occurred. If the enrollment is not
completed within 60 calendar days of the qualifying event, further chances to enroll, if any, depend on the normal rules of the Plan that govern late enrollment.

Except as expressly provided elsewhere in the Plan, coverage will be effective as of the date enrolled.

**Involuntary Loss of Other Coverage (Does not Apply to Class Q Employees)**

If an eligible Employee and/or his or her Eligible Dependent(s) does not enroll in this Plan when first eligible, the Employee and/or Eligible Dependent(s) may later enroll in this Plan outside of the annual Open Enrollment period if each of the following requirements is met:

- The eligible Employee and/or Eligible Dependent was covered under another group plan providing a similar type of coverage at the time coverage under the Plan was offered.
- The eligible Employee’s and/or Eligible Dependent’s coverage under the other group plan providing similar coverage ended as a result of one of the following:
  - Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment.
  - Termination of employer contributions toward such coverage.
  - The Employee and/or Eligible Dependent(s) was covered under COBRA at the time coverage under this Plan was previously offered and COBRA coverage has been exhausted.

An Enrollee who qualifies as stated above may enroll all Eligible Dependents. When only an Eligible Dependent qualifies for special enrollment, but the eligible Employee isn’t enrolled in this Plan, the eligible Employee is also allowed to enroll in this Plan in order for the Eligible Dependent to enroll.

**Enrollee and Dependent Special Enrollment (Does not Apply to Class Q Employees)**

An eligible Employee and Eligible Dependents who previously elected not to enroll in the Plan when such coverage was previously offered may enroll in the Plan at the same time a newly acquired Eligible Dependent is enrolled in the case of marriage, birth or adoption. The eligible Employee may also choose to enroll without enrolling any Eligible Dependents. The eligible Employee may also choose to enroll alone or enroll with some or all Eligible Dependents.

**Premiums**

Your Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by your Group.

**Procedure For Using The Plan**

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained at vsp.com or by contacting VSP Customer Care at 1-800-877-7195. If this list does not cover the geographic area in which you desire to seek services, contact VSP Customer Care.

2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Copayment (if any) to a Member Doctor for services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

**Note:** If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.
5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person’s Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of benefits or Addendum, Covered person is not covered by VSP for medical services and should contact a physician under Covered Person’s medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP’s Customer Service Department for assistance.

Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

6. In the event of termination of a Member Doctor’s membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

Benefit Authorization Process

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Covered Person by Group under this Plan. When Covered Person requests services under this Plan, Covered Person’s prior utilization of Plan Benefits will be reviewed by VSP to determine if Covered Person is eligible for new services based upon Covered Person's Plan’s level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

Benefits And Coverages

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP Plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

Necessary contact lenses, together with professional services, will be provided as indicated on the enclosed insert.

When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown on the enclosed insert. A 15% discount shall also be
applied to the Member Doctor’s usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor’s usual and customary charges.

5. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the enclosed insert, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. Low Vision Services and Materials (applicable only if included in your Plan Benefits outlined on the enclosed insert): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined on the enclosed insert. Consult your Member Doctor for details.

**Copayment**

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet and on the enclosed insert. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

**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. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP’s Customer Care Division at (800) 877-7195.

This vision service Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

**NOT COVERED**

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals.
• Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
• Medical or surgical treatment of the eyes.
• Corrective vision treatment of an Experimental Nature.
• Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
• Services/materials not indicated as covered Plan Benefits on the enclosed insert.

Liability In Event Of Non-Payment

In the event company fails to pay the provider, you shall not be liable to the provider for any sums owed by the vision plan other than those not covered by the plan.

Complaints And Grievances

If Covered Person ever has a question or problem, Covered Person’s first step is to call VSP’s Customer Service Department. The Customer Service Department will make every effort to answer Covered Person’s question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP’s review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP’s receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP’s expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person’s authorized representative. 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.

B. Request for Appeals: If a Covered Person’s claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person’s name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person’s authorized representative should submit all requests for appeals to:

VSP Member Appeals
3333 Quality Drive Rancho
Cordova, CA 95670
1-800-877-7195

VSP’s determination, 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 appeal from the Covered Person or Covered Person’s authorized representative.
If Covered Person disagrees with VSP’s determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (“ERISA”), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Termination Of Benefits

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. Plan Benefits will cease on the date of cancellation of this Plan whether the cancellation is by Group or by VSP due to nonpayment of Premium.

If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion but in no event beyond six (6) months after the termination date of the Plan.
COBRA Continuation Coverage

When group vision coverage is lost because of a qualifying event, as described below, federal laws and regulations known as "COBRA" require that qualified beneficiaries (e.g., you or your spouse or other dependents covered under the Plan) are offered an election to continue such coverage for a limited time. Under COBRA, a qualified beneficiary must apply for COBRA coverage within a certain time period and pay a monthly charge for it.

The Plan must notify you and your dependents of your/their rights under COBRA. The Plan’s third-party plan administrator is responsible to notify members on behalf of the Plan. In such cases, the Plan Sponsor has 30 days in which to notify the Plan’s third-party administrator of your termination of employment, reduction in hours, death, or Medicare entitlement. The third-party administrator then has 14 days after it receives notice of a qualifying event from the Plan Sponsor in which to notify qualified beneficiaries of their COBRA rights.

Coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this Plan. The following provides a summary of how COBRA coverage works.

Qualifying Events And Length Of Coverage

You and your covered dependents can elect to continue coverage for up to 18 consecutive months if coverage is lost because of either of the following qualifying events:

- Your work hours are reduced making you ineligible for the Plan.
- Your employment terminates, except for a discharge due to your gross misconduct.

However, if one of the events listed above follows your entitlement to Medicare by less than 18 months, your spouse and children can elect to continue coverage for up to 36 months starting from the date of your Medicare entitlement.

COBRA coverage can be extended if you lost coverage due to a reduction in hours or termination of employment and either you or one of your dependents is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

Your spouse and children can elect to continue coverage for up to 36 consecutive months if their coverage is lost because of one of the following qualifying events:

- You die.
- You and your spouse legally separate or divorce.
- You become entitled to Medicare.
- A child loses eligibility for dependent coverage.

In addition, the occurrence of one of these events during the 18-month period (29-month period, if disabled) described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions Of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice of Some Qualifying Events

The Plan will offer COBRA coverage only after receiving timely notice that certain qualifying events have occurred. If the procedures are not followed or if the required notice is not given or is late, you or your affected dependent LOSES THE RIGHT TO ELECT COBRA COVERAGE. Except as described below for disability notices, you or your affected dependent has 60 days in which to give notice to the Plan. The notice period starts on the dates described below.
• You or your affected dependent must notify the Plan in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events and Lengths of Coverage." For these events, the 60-day notice period starts on the later of: (1) the date of the qualifying event, or (2) the date you or your affected dependent would lose coverage as a result of the event.

• You or your affected dependent must also notify the Plan if the Social Security Administration determines that you or your dependent was disabled during the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Plan this notice for you.

For determinations of disability, the 60-day notice period starts on the later of: (1) the date of your termination or reduction in hours; (2) the date you or your dependent would lose coverage as the result of one of these events; or (3) the date of the disability determination. Please note: Determinations that you or your affected dependent is disabled must be given to the Plan before the 18-month continuation period ends. This means that you or your dependent might not have the full 60 days in which to give the notice. Please include a copy of the determination with your notice to the Plan. You or your affected dependent must also notify the Plan if you or your dependent is deemed by the Social Security Administration to no longer be disabled within 30 days after the date such determination is made. See "When COBRA Coverage Ends." Important Note: If the Plan informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you’re informed by the Plan.

You Must Enroll and Pay On Time

You must elect COBRA coverage no more than 60 days after the later of (1) the date coverage was to end because of the qualifying event, or (2) the date you were notified of your right to elect COBRA coverage.

Each qualified beneficiary will have an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse and parents may elect COBRA coverage on behalf of their children.

You must send your first payment to the Plan no more than 45 days after the date you elected COBRA coverage. Subsequent monthly payments must also be timely paid to the Plan.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed for Special Enrollment Rights or during the Open Enrollment Period. With one exception, family members added after COBRA begins are not eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under “Qualifying Events and Lengths Of Coverage” earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child’s coverage. COBRA coverage is subject to all other terms and limitations of this Plan.

Keep the Plan Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Plan informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to the Plan. To change your address at any time, please contact The Benefits Service Center at 1-866-644-2696.

When COBRA Coverage Ends

COBRA coverage will end on the last day of the month for which a premium has been paid and in which the first of the following occurs:

• The applicable continuation period expires.
• The next monthly payment isn't paid when due or within the 30-day COBRA grace period.
• When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events and Lengths Of Coverage" in this section), COBRA coverage beyond 18 months ends if there's a final determination that you or your affected dependent is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which premium charges have been paid in the first month that begins no more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Plan with a copy of the Social Security Administration's determination within 30 days after the later of: (1) the date of the determination, or (2) the date on which you or your affected dependent was informed that this notice should be provided and given procedures to follow.
• You or your dependent becomes covered under another group plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
• You become entitled to Medicare after the date you elect COBRA coverage.
• You or your dependent's COBRA coverage is terminated for cause (e.g., for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA beneficiary under the Plan.
• Amazon ceases to offer the Plan to any employee.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the Benefits Service Center at 1-866-644-2696. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group vision 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 Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Health Insurance Portability and Accountability Act (HIPAA)

Vision Service Plan is committed to protecting the privacy of your vision health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires VSP to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.vsp.com.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Employees called to military service have the right to continue vision coverage for up to 24 months by paying the monthly Premiums, even if they are employed by groups that are too small to comply with COBRA. USERRA contains other employment-related requirements, including (but not limited to) the employer having to hold the employee’s position until he/she returns from service. For further information on this act, please contact your legal counsel or insurance producer.

Conversion Option

If your vision coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to VSP to convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and Premium costs may be different from those available under your current plan. There may be a gap in coverage between the dates your coverage under your current Plan ends and the date that coverage begins under an individual policy.

Your Rights Under ERISA

As a participant in this employee benefit health and welfare 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 worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy
of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The 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 Health Plan Coverage**

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

**Prudent Action 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, your union, or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your right 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 for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 a Federal court. If it should happen that the Plan fiduciaries misused 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 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.
Schedule Of Benefits

General
This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

Plan And Schedule: Signature Plan


<table>
<thead>
<tr>
<th>Examination:</th>
<th>Member Doctor Benefit</th>
<th>Non-Member Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses:</td>
<td>Once Every 12 Months</td>
<td></td>
</tr>
<tr>
<td>Frames:</td>
<td>Once Every 12 Months</td>
<td></td>
</tr>
</tbody>
</table>

Copayment
There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of $10.00 payable by the Covered Person to the Member Doctor at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Plan Benefits

Vision Care Services

Vision Examination Covered in Full* Up to $50.00*

Vision Care Materials

Lenses

Single Vision Covered in Full* Up to $50.00*
Bifocal Covered in Full* Up to $75.00*
Trifocal Covered in Full* Up to $100.00*
Lenticular Covered in Full* Up to $125.00*

Frames Covered up to Plan Allowance* Up to $70.00*

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

Contact Lenses

Necessary
Professional Fees and Materials Covered in Full* Up to $210.00*

Elective
Professional Fees** and Materials Up to $130.00 Up to $105.00

*Subject to Copayment, if any.
**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.
Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Member Doctor Benefit</th>
<th>Non-Member Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Vision</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing  
(Covered in Full)  
(Up to $125.00)  
(Includes evaluation, diagnosis and prescription of vision aids where indicated)

Supplemental Aids  
(75% of cost)

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

**NON-MEMBER PROVIDER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.
PLAN BENEFITS FOR AFFILIATE PROVIDERS

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

COPAYMENT
There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a $10.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION - Covered in full* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
   Spectacle Lenses (Single, Lined Bifocal, or Lined Trifocal)

FRAMES - Covered up to the Plan allowance* once every 12 months**

CONTACT LENSES
ELECTIVE
   Elective Contact Lenses are covered up to $130.00 once every 12 months**
The Elective Contact Lens allowance applies to materials only.

NECESSARY
   Necessary Contact Lenses are covered up to $210.00* once every 12 months**
Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first date of service
LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00†
- Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00†

†Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP’s quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.