J. M. Huber Corporation

Vision Care Plan

Summary Plan Description

Effective January 1, 2010

Eligible Employees have the option to elect this Vision Care Plan. The Plan includes an eye examination and other benefits as described in this Summary Plan Description.

Eligibility

Employees

You are eligible to enroll if you are a regular full-time employee of J.M. Huber Corporation or an affiliate that is a participating employer in the Plan, unless you are an employee represented by a union and covered by a collective bargaining agreement. **Full-time employees are employees hired to work on average a 40-hour work week on a regular basis.**

If you are a temporary employee or a part-time employee, you are not eligible to participate in this Plan. You are a temporary employee if you are hired to work on a full-time or part-time basis with the understanding that your employment will be terminated no later than upon your completion of a specific assignment.

Waiting Period

Initial Employee Group: None.

New Employee Group: Full-Time - The first day of the month following date of hire.

Employees transferring from Non-Participating Company affiliate or to an eligible class: None

Effective Date of Your Insurance

You will become covered on the date you elect the coverage by signing an approved enrollment form, but no earlier than the date you become eligible. You will not be denied enrollment for this plan due to your health status.

You will become covered on your first day of eligibility, following your election, if you are in Active Service on that date.

You will not be enrolled for this plan if you do not enroll within 31 days of the date you become eligible.

Dependents

Your eligible dependents are your spouse and your child dependents.

Your spouse is your legal spouse as recognized under federal law with the exception of common law spouses which are not eligible.

- Your child dependent is an unmarried person under the age of **19,** who:
  - is your natural born child, or
  - is legally adopted by you, or
  - is your stepchild and either of the following conditions is present:
    - you lawfully claim the stepchild as your tax dependent, or

- you and your spouse provide at least half of the stepchild's support and the stepchild resides with you for at least half of the calendar year

Foster children are not eligible dependents under the Plan. Also a child who was formerly your stepchild but from whose natural parent or stepparent you have become divorced or legally separated, is not an eligible dependent.

Qualified Medical Child Support Orders are honored by the Plan under Federal Requirements. Refer to the section of this booklet called "Qualified Medical Child Support Order (QMSCO)" for more details.

Student Dependent Coverage

Your unmarried child dependents between the ages of **19** and **24**, who are full-time students at an accredited institution of higher education, are eligible for dependent coverage until the end of the calendar month in which their **24th** birthday occurs. However, if before the end of that month your child no longer qualifies as a full-time student or fails to satisfy the definition of a child dependent for any other reason (for example, by becoming married), coverage will end on the last day of the month in which the child no longer meets all of the requirements to be an eligible dependent.

Important! You must notify the Company of your dependent's ceasing to qualify as a child dependent under this Plan. If you fail to do so within 60 days from the end of the benefit month in which your child no longer qualifies as an eligible dependent, you will be required to reimburse the Plan for the full cost of any benefits provided with respect to your ineligible dependent after the coverage end date. The child is not eligible for "Special Enrollment" rights during the benefit year.

Disabled/Handicap Dependents

Coverage will continue if your child dependent is 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap.

This plan is only available to participating Affiliates as defined by J.M. Huber Corporation.

Enrollment Procedure

You will be required to enroll in a manner determined by EyeMed and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within 31 days of your Eligibility Date. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels the insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.

Coverage will end upon the earliest of the last day of the month in which:

- dependent child marries
- dependent child becomes employed
- dependent child becomes eligible for other health insurance as a result of employment
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

- **Important!** Your failure to make any required contribution for coverage by the end of the period in which it will be accepted by the Plan will result in your complete loss of any entitlement to further coverage under the Plan, during the remainder of the year and all future years.
- Coverage for your spouse will end on the date of your spouse's death or at the end of the benefit month in which you divorce or become legally separated from your spouse. You must notify the Company of your spouse’s death, divorce or legal separation. If you fail to do so within 60 days from the end of the month in which your divorce or legal separation occurs, you will be required to reimburse the Plan for the full amount of any benefits provided for your former spouse after the date coverage ends for him or her.
- When your spouse loses coverage due to your death or divorce or legal separation, he or she may have the right to elect COBRA continuation coverage. When your child loses coverage due to your death or as a result of no longer qualifying as an eligible dependent under the Plan,

he or she may have the right to elect COBRA continuation coverage. Refer to the section of this booklet called "COBRA Continuation Rights Under Federal Law" for more details.

Claims Administrator

The Claims Administrator for the Vision Care option is EyeMed Vision Care. The benefits paid by the Vision Care plan are based on a reimbursement fee schedule. The fee schedules are based on the rates the provider has agreed upon for providing such services through the EyeMed Access network.

The EyeMed Network

EyeMed Vision Care's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision locations.To locate EyeMed Vision Care providers near you, visit www.eyemedvisioncare.com and choose the **Access Network**. You may also call EyeMed's Customer Care Center at ***1-866-723-0513***. EyeMed's Customer Care Center can be reached Monday through Saturday 8:00 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

COVERED VISION SERVICES – EyeMed Access Plan H

I. Examination Benefit

A. ***In-Network Benefit.*** A Member is entitled to a paid-in-full comprehensive spectacle eye examination, including dilation, performed by a Participating Provider.

B. ***Out-of-Network Benefit.*** A Member is entitled to a comprehensive spectacle eye examination with dilation, up to a $35.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to $35.00 toward an eye examination after submitting a complete claim.

C. ***Member Pays***. There is no co-payment for in-network benefit only.

D. ***Fitting and Follow up*** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.

1. **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Member pays up to $55.**
2. **Premium** Contact Lens – all lens designs, materials and speciality fittings other than Standard Contact Lenses. **Premium benefit is a 10% discount toward fit and follow-up. The member is responsible for 90% of the retail price at the time of service.**

E. ***Out of Network, Fitting and Follow up*** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.

1. **Standard** Contact lens – no OON benefit.
2. **Premium** Contact Lens – no OON benefit.

F. ***Benefit Frequency.*** Once every twelve (12) months.

II. Contact Lens Benefit

A. ***In-Network Benefit.*** In lieu of lenses, all Members are entitled to non-disposable, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.

1. ***Non-disposable***-a $130.00 allowance applied toward non-disposable contact lenses. The Member is responsible for 85% of the balance amount over $130.00 at the time of service
2. ***Disposable***-a $130.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over $130.00 at the time of service.
3. ***Medically Necessary***-a paid in full benefit toward medically necessary contact lenses.

B. **Out-of-Network Benefit**. In lieu of the lenses benefit, for contact lenses obtained from an out-of-network provider, a Member is entitled to the following:

1. ***Non-disposable***-a Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
2. ***Disposable***-a Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
4. ***Medically Necessary***-a Member is entitled to be reimbursed up to $200.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

C. **Member Pays.** There is no co-payment.

D. **Benefit Frequency**. Once every twelve (12) months.

III. Frame Benefit

A. ***In-Network Benefit.*** A Member is entitled to a $130.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the $130.00 at the time of service.

B. ***Out-of-Network Benefit.*** A Member is entitled to a reimbursement of up to $60.00 toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

C. ***Member Pays***. There is no co-payment.

D. ***Benefit Frequency***. Once every twenty four (24) months.

IV. Lens Benefits

A. ***In-Network Benefit.*** A Member is entitled to single vision, bifocal, trifocal and lenticular lenses.

B. ***Member Pays***. There is $10.00 co-payment.

C. ***Lens Options*** A Member is entitled to the following lens options for the additional amounts set forth below:

Ultra Violet Coating	$15.00
Tint (Solid & Gradient)	$15.00
Standard Scratch Resistant	$15.00
Standard Polycarbonate	$40.00

Standard Progressives (add-on to bifocal)*	$65.00
Standard Anti-Reflective	$45.00
Other Add-Ons	20% discount

D. ***Out-of-Network Benefit.*** A Member is entitled to be reimbursed for the following: up to $25.00 for single vision; up to $40.00 for bifocal; up to $55.00 for trifocal. The Member must pay the out-of-network provider in full at the point-of-service and file a complete claim to receive the reimbursement.

E. ***Benefit Frequency***. Once every twelve (12) months.

Note: Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance. Lost or broken materials are not covered.

- Standard Progressive Lenses include, but are not limited to the following trade names; Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.

V. Laser Vision Benefit

A Member is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the Member will be responsible for and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

Accessing the Benefit

1. To locate the nearest U.S. Laser Network provider, a Member must call 1-877-5LASER6.
2. After the Member has located a U.S. Laser Network provider, the Member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Member. The Member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the Member is a good candidate for laser vision correction, the Member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the Member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the Member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the Member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the Member remits the deposit, U.S. Laser Network will issue to the Member an authorization number confirming the EyeMed discount. This authorization number will be sent to the Member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the Member to pay or arrange to pay the balance of the fee.

8. After the treatment, the Member should follow all post-operative instructions carefully. In addition, the Member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

VI. Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on remaining balance at Participating EyeMed Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, disposable contact lenses or services provided by laser providers. Members are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, members are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses.

VII. Limitations and Exclusions

The following services and supplies are not covered under the Plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Corrective eyewear required by an employer as a condition of employment and safety eyewear
- Services provided as a result of any workers' compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Two pairs of glasses in lieu of bifocals
- Services or materials provided by any other group benefit plan providing vision care; or
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design.
- Applicable taxes
- Visual Display Terminal (VDT) Exam
  Benefits are not provided for services or materials arising from: Orthoptic or vision training; subnormal vision aids, and any associated supplemental testing. Medical and/or surgical treatment of the eye, eyes, or supporting structures. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under the Plan. Services provided as a result of any Worker's Compensation law. Plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount). Two pair of glasses in lieu of bifocals.

Coordination of Benefits

EyeMed is typically considered the primary vision benefits carrier. In cases where EyeMed is considered the secondary carrier, EyeMed will process the claim as secondary. Payment as the secondary carrier is based on the Explanation of Benefits (EOB) issued by the primary carrier. If the claim is in-network, the provider should attach a copy of the EOB with the claim submitted to EyeMed. If the claim is out-of-network, the member should attach a copy of the primary carrier EOB to the OON claim form and itemized receipts.

Once the claim is received, EyeMed will review the claim and EOB of the primary carrier and determine the amount payable, which is equal to EyeMed's liability, less the amount paid by the primary carrier. If the amount paid by the primary carrier is equal to or greater than EyeMed's liability, the plan will pay zero. If the amount paid by the primary carrier is less than EyeMed's liability, the plan will pay the amount equal to EyeMed's liability, less any applicable co-pays. If services denied by the primary carrier are covered under the EyeMed vision plan, EyeMed will reimburse up to the allowed amount less any co-pays. The calculation will be the same as if we paid as the primary carrier.

SAMPLE SAVINGS

The following examples illustrate how your benefit would be applied to the services received at any participating EyeMed provider's office or location:

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10.00
A frame up to a value of $100:	the member pays $0.00
One pair of bifocal lenses:	the member pays $10.00
Ultraviolet coating:	the member pays $15.00
The total cost to the member is:	**$35.00**

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10.00
A frame up to a value of $150:	the member pays $16.00
A pair of single vision lenses:	the member pays $10.00
Standard anti-reflective coating:	the member pays $45.00
The total cost to the member is:	**$81.00**

The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed's Member Services Department 866-723-0513 or using the Provider Locator service through EyeMed's web site www.eyemedvisioncare.com to locate the EyeMed Provider closest to you.

Note: The benefits are underwritten by Fidelity Security Life Insurance Company. If you have any questions or concerns, please contact EyeMed Vision Care.

Filing Claims

Using your Vision Benefit

Before you go to a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Card, if applicable, or if you should forget to take your card be sure to say that you are participating in the J.M. HUBER Corporation Vision Plan so that eligibility can be verified. Confirm the provider is an in-network provider for the Access Network.

EyeMed Vision Care Customer Service can be reached seven days a week Monday through Saturday 8:00 am to 11:00 pm and Sunday 11:00 am to 8:00 pm Eastern Time at 866-723-0513.

When you receive services at a participating EyeMed Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in this Summary Plan Description. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, Oh 45040-7111

For your convenience, an EyeMed out-of-network claim form is available at www.eyemedvisioncare.com or by calling EyeMed's Customer Care Center at ***1-866-723-0513***.

Time Frames for Processing Claims

Health Claim Processing Activity	Post Service Claims
Plan Initial Determination • Initial Review Decision • Extension Period, including extension for Missing Information	 30 calendar days 15 calendar days

Plan Notice of Incomplete Claim • Missing Information	Included in Extension Time above
Claimant Time to Complete Claim • Provide Additional Information • Comply with Required Filing Procedure	45 calendar days 45 calendar days

Time Frames for Responding to Appealed Claims

Activity	**Time Frame**
Claimant Appeal of Adverse Determination (Denial or Reduction)	180 calendar days
Plan Decision on Appeal	60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.

- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.

- Additional information from the member's eye care provider that will assist EyeMed Vision Care in completing its review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040
Fax: 1-513-492-4999

EyeMed will review your appeal for benefits and notify you in writing of its decision, the reasons for the decision, a reference to specific plan provisions, statement of any guideline, rule or protocol relied on, if appropriate, a statement of the specific medical determination used to make the decision and the specialization of any physician or other professional consulted, if appropriate, along with a description of the appeal process and timeframe. For more information

on your rights and how to file a formal appeal under the Employee Retirement Income Security Act of 1974, as amended (ERISA), refer to the appropriate section of your Summary Plan Description. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory Agency. You are entitled to receive, free of charge, upon request, access to and copies of documents, records and other information relevant to your claim.

Complaint Procedure

A complaint is any dissatisfaction expressed by a Member in writing to EyeMed regarding unresolved inquiries submitted in writing, dissatisfaction with quality of care, dissatisfaction with Provider services, materials or facility, or dissatisfaction with plan administration. If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or plan administration, you should either file a formal complaint by writing to EyeMed at the address indicated above or call the EyeMed Vision Care's Customer Care Center at ***1-866-723-0513*** to request resolution.

When you choose to call in your dissatisfaction, the EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues you have raised. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed will use its best efforts to communicate back with the member within four (4) business days with a decision or resolution to the issues or questions raised. If you are not satisfied with the resolution from the Member Service representative or the issue cannot be resolved by Member Services, you should file a formal complaint to the Quality Assurance department to the address noted above.

If you choose to file a written formal complaint about your dissatisfaction, the EyeMed Vision Care Quality Assurance Department will log your complaint and send you a written acknowledgement within three (3) business days. The acknowledgement letter may also request additional information necessary to investigate the complaint. Quality Assurance will investigate the complaint with the EyeMed Provider and notify you in writing of its decision. The resolution response includes a statement of the decision, reason(s) for the decision, statement of any guideline, rule or protocol relied on, if appropriate, specific medical determination, clinical basis and/or contractual criteria used to make the decision and the specialization of any physician or other Provider consulted as applicable, along with a description of the complaint appeal process and timeframe.

If you remain dissatisfied with the complaint resolution, you may file a formal written complaint appeal to EyeMed Quality Assurance and submit any new information and a new independent review will occur. The reconsideration process is the same as the first complaint review and conducted by a review committee who were not involved in the original review. Your complaint appeal will be acknowledged in writing. EyeMed will review your complaint appeal and notify you in writing of its decision.

The resolution response includes a statement of the decision, reason(s) for the decision, statement of any guideline, rule or protocol relied on, if appropriate, specific medical determination, clinical basis and/or contractual criteria used to make the decision and the specialization of any physician or other Provider consulted as applicable, along with the contact information of your state Bureau of Insurance, as applicable.

Time Frames for Responding to Member Complaints

Activity	Time Frame
Occurrence of Dissatisfaction	180 calendar days
EyeMed Decision on Complaint	30 calendar days
Member Appeal of Complaint Resolution	30 calendar days

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

A. Continuation of Vision Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA); and
- you are an eligible Employee under the terms of that Act.

The cost of your vision insurance during such leave must be paid by you.

B. Reinstatement of Canceled Insurance Following Leave

If your coverage is canceled or ceases during a leave of absence that qualifies under FMLA (for example, because you opt not to continue coverage or due to your nonpayment of the premiums), you may resume coverage upon your return to Active Service on the same terms as before or as otherwise required by FMLA. You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

If you do not return to Active Service at the end of your FMLA leave, under special rules that apply if an employee does not return to work at the end of the leave, some individuals may be entitled to elect COBRA even if they were not covered under the plan during the leave. Contact your Employer for more information about these special rules.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

COBRA Continuation Rights Under Federal Law For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also

cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- when the Employer ceases to provide any group health plan to any employee;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs;

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date your
Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Additional Information Provided by J.M. Huber Corporation

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Your Plan Administrator has determined that this information together with the information contained in your booklet is the Summary Plan Description required by ERISA.

The name of the Plan is:

J.M. Huber Corporation Vision Care Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

J.M. Huber Corporation
499 Thornall St
8TH Floor
Edison, NJ 08837
732-549-8600

Employer Identification Number (EIN)	Plan Number
130860350	501

Type of Plan:
Group Health Plan

Type of Administration:
Insurer Administration
EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

Plan Administrator:
J.M. Huber Corporation
499 Thornall St
8TH Floor
Edison, NJ 08837
732-549-8600

Agent For Service of Legal Process:
J.M Huber Corporation
General Counsel

499 Thornall St
8TH Floor
Edison, NJ 08837
732-549-8600

End of Plan Year:
December 31

Source of Contributions:
Employee funded.

Procedure for Amending the Plan:
The Plan Sponsor may amend the Plan from time to time by a written instrument signed by it.

Plan Modification, Amendment and Termination

The Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of 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 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 Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy 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 person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- 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 preexisting 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 responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a

Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.