Luxottica Group Benefit Plan

# SUMMARY PLAN DESCRIPTION

Luxottica North America

Luxottica Group Benefit Plan

# SUMMARY PLAN DESCRIPTION

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## Contact Information

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| **Adoption Assistance** | benefitsdept@luxotticaretail.com |
| **Aetna Dental (PPO and DMO)** | 800-843-3661, www.Aetna.com |
| **Aetna Long Term Disability** | 866-277-8113 |
| **Aetna Part-Time Associate Coverage** | 800-977-6974 |
| **Aetna Voluntary Benefits** | 866-431-8484 |
| **Anthem Employee Assistance Program (EAP)** | 800-865-1044 |
| **Anthem Life** | 800-813-5682 [Claims], 866-551-0315 [Customer Service] |
| **Anthem Medical** | 866-251-1701, www.Anthem.com |
| **Anthem Nurseline** | 888-596-9473, TDD-TYY 800-877-8044 |
| **Luxottica Human Resource Service Center** | 866-431-8484,<br>**Flexible Spending Accounts:**<br>YSA / PO Box 785040<br>Orlando, Florida 32878-5040<br>Fax No. 888-211-9900, www.LuxotticaBenefits.com<br>**Health Savings Account Administration**<br>www.LuxotticaBenefits.com |
| **HealthEquity(Health Savings Accounts)** | 1-877-713-7712, www.myhealthequity.com |
| **COBRA** | 866-431-8484, www.LuxotticaBenefits.com<br>**Enrollment, Payments and Notices:**<br>Luxottica Human Resources Service Center, P.O. Box 0709<br>Carol Stream, Illinois 60132-0709 |
| **EyeMed Vision Care** | 844-345-0578, eyemedvisioncare.com |
| **GeoBlue**<br>[Expatriate Medical, Dental and AD&D Coverage] | 610-254-8771[call collect]<br>800-257-4823 [toll free inside the U.S.]<br>globalhealth@hthworldwide.com |
| **Group Universal Life** | 866-431-8484 |
| **HMSA** [Associates in Hawaii] | 866-431-8484 |
| **Humana Medical**<br>[Associates in Greater Cincinnati and Northern Kentucky] | 800-601-5031, www.Humana.com |
| **Humana First Nurseline**<br>[Associates in Greater Cincinnati and Northern Kentucky] | 800-622-9529 |
| **Luxottica North America Risk Management Department**<br>[Business Travel Insurance] | 866-431-8484 |
| **MCS**<br>[Associates in Puerto Rico] | 866-431-8484 |
| **Sedgwick (Leave of Absence, Short Term Disability)** | 866-431-8484 |

## Things to Keep in Mind

- We strongly recommend that You read the entire SPD.
- This SPD describes the Plan's Benefit Programs and Non-Plan Programs as of January 1, 2016.
- The Non-Plan Programs are not legally considered part of the Plan. However, they are described in this SPD for Your convenience.
- The words "We," "Us" and "Our" refer to Luxottica North America. The words "You," "Your" and "Yourself" refer to an eligible Associate or an eligible Associate who is a Participant (as indicated by the context in which the word is used).
- The Plan has Benefit Programs that are "Company Funded" and programs that are "Insured."
- Luxottica North America is only responsible to pay for the claims under the Company Funded Benefit Programs. Various Insurers are responsible to pay for the claims under the Insured Benefit Programs.
- The Plan is governed by this SPD, the Wrap Plan Document, the Section 125 Plan Document and the Benefits Booklets. This SPD and the Wrap Plan Document supplement the Benefits Booklets and should not be interpreted to give You, Your spouse, Domestic Partner, dependents or beneficiaries any rights or benefits not otherwise described in the Benefits Booklets. If the provisions of this SPD conflict with the provisions of those other documents, the Plan Administrator has the sole discretion to interpret the terms and purpose of the Plan to resolve the conflict.
- If You, or a member of Your family improperly receive benefits under the Benefit Programs, or Non-Plan Programs, You may have to pay those amounts back to Luxottica North America or the applicable Insurer. Also, if Plan benefits, or Non-Plan Program benefits, are paid because You, and/or a member of Your family's, fraudulent, improper, or dishonest actions, You may lose Your Plan coverage and be subject to disciplinary action, including, termination of employment. For example, if You or a Family Member misrepresents tobacco usage, that is considered a fraudulent, improper and dishonest action that could trigger this provision.
- Luxottica North America may modify, amend or terminate the Plan, its Benefit Programs, or the Non-Plan Programs, any time without prior notice or consent.

Capitalized words and phrases are defined in the definitions section or the section in which they are used.

## Eligibility

| Full-Time Benefits | | | |
|---|---|---|---|
| Programs | Eligible Individuals | Coverage Effective Date | Claims Administrators, Insurers and Benefit Provisions |
| **Employee Assistance Program** | • Full-Time Associates<br>• Part-Time Associates (in Canada only)<br>• Spouse, Dependents and Domestic Partners | Date of hire | • Anthem EAP is the Insurer and Claims Administrator.<br>• This SPD contains the benefit provisions. |
| **Medical**<br>**Inside Cincinnati/Northern KY:**<br>(1) Company Funded Humana Traditional PPO and Anthem High Deductible PPO;<br>(2) Insured GeoBlue Expatriate medical.<br>**Outside Cincinnati/Northern KY:**<br>(1) Company Funded Anthem Traditional PPO and High Deductible PPO<br>(2) Insured MCS PPO (in Puerto Rico);<br>(3) Insured HMSA HMOs (in Hawaii);<br>(4) Insured GeoBlue Expatriate medical. | • Full-Time Associates<br>• Part-Time Grandfathered Associates (not eligible for GeoBlue Expatriate)<br>• Part-Time Associates in Hawaii (not eligible for GeoBlue Expatriate)<br>• Part-Time Associates in San Francisco who are subject to the San Francisco Health Care Accountability Ordinance<br>• Dependents<br>• Spouse (subject to possible surcharge)<br>• Domestic Partners (subject to possible surcharge)<br>• Household Dependent (subject to possible surcharge) | 1st of the month following 30 Days Of Employment as a Full-Time Associate<br>• 29th Day Of Employment for coverage in the Insured HMSA | • Humana is the Claims Administrator for the Company Funded option for Associates in Greater Cincinnati/Northern KY.<br>• Anthem is the Claims Administrator for Company Funded options.<br>• Various companies are the Insurers, and the Claims Administrators, for the Insured options.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific provisions. |
| **Dental**<br>**Company Funded Options:** Aetna PPO<br>**Insured Options:** (1) Aetna DMO; (2) MCS PPO (in Puerto Rico); and (3) GeoBlue Expatriate dental | • Full-Time Associates<br>• Part-Time Grandfathered Associates (not eligible for GeoBlue Expatriate)<br>• Spouse and Dependents<br>• Domestic Partners | | • Aetna is the Claims Administrator for the Company Funded options.<br>• Aetna, GeoBlue and MCS are the Insurers, and the Claims Administrators, for the Insured options.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific provisions. |
| **Associate Life/AD&D**<br>• Insured Basic Life/AD&D (1x Annual Base Pay)<br>• Insured Supp. Life/AD&D (1-5x Annual Base Pay)<br>• GeoBlue Expatriate AD&D ($50,000) | • Full-Time Associates | | • Anthem and GeoBlue are the Insurers and the Claims Administrators.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific provisions. |
| **Dependent And Spousal Life**<br>• Insured Dependent Life<br>• Insured Spousal Life | • Spouse, Dependents and Domestic Partners of Full-Time Associates | | |

| Full-Time Benefits | | | |
|---|---|---|---|
| Programs | Eligible Individuals | Coverage Effective Date | Claims Administrators, Insurers and Benefit Provisions |
| **Flexible Spending Accounts**<br>• Health Care FSA<br>• Dependent Care FSA | • Full-Time Associates<br>• Full-Time Associates who enroll in the Anthem High Deductible PPO are NOT eligible for Health Care FSA | | • Aon Hewitt is the Claims Administrator.<br>• This SPD summarizes the benefit provisions. |
| **Long Term Disability** | • Full-Time Associates | The 181st Day Of Employment as a Full-Time Associate | • Aetna is the Insurer and the Claims Administrator.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklet contains the specific provisions. |
| **Tuition Reimbursement** | • Full-Time Associates | 1st of the month following 30 Days Of Employment as a Full-Time Associate | • Aon Hewitt administers this Non-Plan Program.<br>• This SPD contains the benefit provisions.<br>• For more information on eligibility and benefits for the Executive Long Term Disability program, please see the summary plan description for that plan. |
| **Adoption Assistance** | • Full-Time Associates | 1st of the month following 30 Days Of Employment as a Full-Time Associate | • Luxottica North America's Benefits Department administers this Non-Plan program.<br>• This SPD contains the benefit provisions. |
| **Short Term Disability Benefits** | • Short term disability benefits for eligible Full-Time Associates are provided under the Luxottica Short Term Disability Plan. For more information on eligibility and benefits, please see the summary plan description for that plan or contact the Luxottica Human Resources Service Center. | | |
| **Voluntary Benefits**<br>• Accident<br>• Critical Illness | • Full-Time Associates<br>• Part-Time Associates<br>• Spouse and Dependents<br>• Domestic Partners | 1st of the month following 30 Days Of Employment as a Full-Time or Part-Time Associate | • Aetna is the Insurer and Claims Administrator. Claims and appeals under the voluntary benefits program are administered in accordance with the applicable provisions described in the Claims And Appeals Procedures section of this SPD.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific provisions.<br>• The ERISA Rights portion of the General Plan Information And ERISA Rights section of this SPD applies to the voluntary benefits program. |

| Full-Time Benefits | | | |
|---|---|---|---|
| Programs | Eligible Individuals | Coverage Effective Date | Claims Administrators, Insurers and Benefit Provisions |
| **Voluntary Benefits**<br>• Group Universal Life | • Full-Time Associates | • 1st of the month following 30 Days Of Employment as a Full-Time Associate | • Allstate is the Insurer and Claims Administrator. Claims and appeals under the voluntary benefits program are administered in accordance with the applicable provisions described in the Claims And Appeals Procedures section of this SPD.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific provisions.<br>• The ERISA Rights portion of the General Plan Information And ERISA Rights section of this SPD applies to the voluntary benefits program. |

| Part-Time and Casual Part-Time Benefits | | | |
|---|---|---|---|
| Programs | Eligible Individuals | Coverage Effective Date | Claims Administrators, Insurers and Benefit Provisions |
| • **Fixed Indemnity Medical**<br>• **Insured Dental**<br>• **Insured Hospital Indemnity**<br>• **Insured Associate Basic Life**<br>• **Insured Short Term Disability** | • Part-Time Associates<br>• Casual Part-Time Associates<br>• Spouses and Dependents | 1st of the month following or coinciding with 30 Days of Employment | • Aetna is the Insurer and the Claims Administrator.<br>• This SPD briefly summarizes these coverage options. The Benefits Booklets contain the specific benefit provisions. |

| Other Benefits | | | |
|---|---|---|---|
| Programs | Eligible Individuals | Coverage Effective Date | Claims Administrators, Insurers and Benefit Provisions |
| **Vision**<br>• Eye Exam<br>• Complimentary Eyewear Certificates [upon reaching Your employment anniversary date] | • All Associates<br>• Spouse and Dependents<br>• Domestic Partners | Hire date | • The Luxottica Human Resources Service Center administers the complimentary eyewear certificates and EyeMed Vision Care is the Claims Administrator for the vision exam benefits.<br>• This SPD contains the benefit provisions. |
| **Business Travel Insurance** | • All Associates | Hire date | • Federal Insurance Company (Chubb) is the Insurer and the Claims Administrator.<br>• This SPD briefly summarizes the coverage. The Benefits Booklets contains the specific benefit provisions. |
| **Pre-Tax Premium Payment Feature** | • Medical and Dental. All Associates may pay their portion of premiums for prospective medical and dental coverage on a pre-tax basis unless otherwise specifically provided.<br>• Life Insurance. Full-Time Associates may pay their portion of premiums for prospective Associate supplemental life/AD&D coverage on a pre-tax basis. | The date an Associate becomes eligible for the underlying Benefit Program coverage for which premiums are being paid. | • Luxottica North America administers Associates' pre-tax premium payments.<br>• This SPD summarizes this feature's provisions. |

## Enrollment and Participation

You are responsible for ensuring that the information (e.g., address, email address) listed in My BLU HR Access is up to date and accurate. We will use that information for all Plan purposes.

### When To Enroll In The Plan

1. **Newly Eligible Associates.**
   You and Your Family Members should enroll in the Plan as soon as possible after You are hired by Luxottica North America or first become eligible (e.g., become a Full-Time Associate). If You don't complete the enrollment procedures described below before the date a Benefit Program's coverage becomes effective, You won't be able to enroll in the Plan until the earliest of the following events occur.

   a. The next annual enrollment period for coverage effective the following January 1st.

   b. There is a Qualified Status Change Event (including an event that triggers a HIPAA Special Enrollment Period).

   c. The Plan Administrator approves a Qualified Medical Child Support Order ("QMCSO").

   You can revoke Your election to enroll in the Plan anytime prior to the date a Benefit Program's coverage becomes effective.

   Coverage under the Benefit Programs becomes effective for You, and Your eligible Family Members for whom You elected coverage, on the "coverage effective dates" in the chart in the ***Eligibility*** section of this SPD. Unless specifically provided in this SPD or the applicable Benefits Booklet, Your Family Members cannot be covered under the Benefit Programs unless You are also covered.

   **Example:** Assume You are hired as a Full-Time Associate on June 9, 2015 and remain continuously employed as a Full-Time Associate.

   - Your vision, employee assistance and business travel insurance benefits automatically become effective on June 9, 2015.
   - If elected, Your medical, dental, Flexible Spending Account (if eligible), Health Savings Account (if eligible), Life/AD&D coverages and voluntary benefits become effective on August 1, 2015.
   - You are eligible for long term disability benefits if You become disabled on or after December 7, 2015.
   - You are eligible to receive Your first annual complimentary eyewear certificate on June 9, 2016.
   - You are eligible for tuition reimbursement on August 1, 2015.

- You are eligible for adoption assistance on August 1, 2015.

**2. Annual Enrollment.**

During each annual enrollment period, You may enroll Yourself and Your eligible Family Members in the Plan. You may also change Your existing benefit elections. Your coverages become effective on January 1st of the following calendar year.

Each fall, the communications department will announce the annual enrollment period.

**3. Qualified Status Change Events.**

a. **General.** If a Qualified Status Change Event occurs, You may enroll Yourself and Your eligible Family Members in the Plan. You may also be able to change Your existing elections. Your coverage changes generally become effective on the date of the event.

Please keep in mind that any new election generally must be consistent with Your Qualified Status Change Event. That means the election must be because of, and correspond with, the event. Although documentation may not be required at the time of Your Qualified Status Change Event, the Luxottica Human Resources Service Center may request that documentation at a later date.

If You become entitled to a HIPAA Special Enrollment Period because You lose other medical or dental coverage, gain a new Spouse or Dependent through marriage, birth, adoption or Placement For Adoption, lose eligibility for Medicaid or coverage under a state children's health insurance program or become eligible for a state premium assistance subsidy under the Plan from Medicaid or a state children's health insurance program, any medical and/or dental elections You are entitled to make under HIPAA can be made under the Qualified Status Change Event rules.

b. **Time Limits For Enrollment/Election Changes.** You must complete the enrollment procedures described in the "***Enrollment Procedures***" section of this SPD, or change Your election, no later than 30 days after the date of the Qualified Status Change Event unless You lose eligibility for Medicaid or coverage under a state children's health insurance program, or become eligible for a state premium assistance subsidy under the Plan from Medicaid or a state children's health insurance program. In those situations, You have 60 days from the date of the event to enroll or change Your existing elections.

Notwithstanding the above, if Your employment status change (i.e., part-time to full-time status or vice versa) within Luxottica North America is not entered into Luxottica North America's HR system in a timely manner by the company, You have 60 days from the date Your employment status change is entered into the system to enroll or change Your existing elections, unless otherwise provided by the Plan Administrator. In that situation, You will only be eligible to receive refunds of premiums for up to 60 days of coverage. However, under no circumstances will You receive refunds of premiums for coverage in a prior Plan Year, or for coverage under which benefits were paid on Your behalf during the period in question.

**Example:** Effective December 1, 2015, Your employment status with Luxottica North America changed from full-time to part-time. Your status change was not entered into Luxottica North America's HR system, and You did not change Your benefit elections, until February 1, 2016. You will only be eligible to receive a refund of the premiums for the Benefit Program coverage You had during January of 2016, assuming no benefits were paid on Your behalf under those Benefit Programs during January.

c. **Vision Coverage.** You and Your Covered Family Members may change vision coverage elections at any time in accordance with the Plan's procedures.

**4. Qualified Medical Child Support Orders.**

If Your child is the subject of a support order and You are participating in the medical and dental Benefit Programs, the child will be enrolled in those Benefit Programs (if required by the order) after Luxottica North America determines the order is a QMCSO. You must begin paying for the child's coverage. If You are participating in the MCS (Puerto Rico) or HMSA (Hawaii) plans and the child lives outside the service area, You and Your child will be enrolled in one of the Company Funded medical and dental coverage options.

If You are not participating in the medical and dental Benefit Programs, but are eligible to participate, You must immediately enroll Yourself, and Your child in the medical and dental Benefit Programs required by the QMCSO, and begin paying for coverage. If You don't enroll, Luxottica North America is legally required to enroll You and Your child in one of the Company Funded medical and dental coverage options. If You are not eligible to participate in the medical and dental Benefit Programs, the child will not be enrolled in any medical or dental Benefit Program until You become eligible. Once You become eligible, You must immediately enroll Yourself, and Your child in the medical and dental Benefit Programs required by the QMCSO, and begin paying for coverage. If You don't enroll, Luxottica North America is legally required to enroll You and Your child in one of the Company Funded medical and dental coverage options.

If the QMCSO does not identify which specific medical Benefit Program option Your child must be enrolled in, Luxottica North America will enroll Your child (and, if applicable, You) in the medical HDHP coverage.

An otherwise ineligible individual is not eligible for Plan coverage merely because coverage is required by a court order which is not a QMCSO.

**5. Rehires/Again Becoming Eligible.**

Except as otherwise specified below, if You are rehired by Luxottica North America (or again become eligible for benefits) within 13 weeks after Your most recent employment with Us (or Your most recent eligibility) ended, and You participated in the Plan's Benefit Programs prior to Your termination (or loss of eligibility), You will have Your participation in the Plan's Benefit Programs reinstated in the same coverage option(s) as of the first of the month following the date You are rehired (or again become eligible for benefits). If the coverage option in which You were participating has changed or is no longer in existence as of this date, then You may elect to participate in another comparable coverage option (if

any), as determined by Luxottica North America. If either of the following are true, You will be treated as a newly hired Associate when You are rehired (or again become eligible).

a. You are rehired (or again become eligible) more than 13 weeks after Your most recent employment with Us (or eligibility) ended.

b. You were not participating in the Plan's Benefit Programs at the time of Your termination (or loss of eligibility).

If You are treated as a newly hired Associate, You again will have to satisfy the Plan's waiting periods before becoming a Participant.

If You are rehired by Luxottica North America (or again become eligible for benefits) within 13 weeks after Your most recent employment with Us (or Your most recent eligibility) ended, and You were eligible for the Plan's short term disability or long term disability Benefit Programs prior to Your termination (or loss of eligibility), You will have Your eligibility in the Plan's short term disability and/or long term disability Benefit Programs reinstated as of the first of the month following the date You are rehired (or again become eligible for benefits). If You are rehired by Luxottica North America (or become eligible for benefits) within 13 weeks after Your most recent employment with Us ended, and You were not eligible for the Plan's short term disability or long term disability Benefit Programs prior to Your termination, You will be treated as a newly hired Associate, and You again will have to satisfy any applicable waiting and/or elimination periods which correspond to these Benefit Programs.

If You are rehired by Luxottica North America (or again become eligible for benefits) within 13 weeks after and within the same calendar year as Your most recent employment with Us (or Your most recent eligibility) ended, and You participated in the Plan's Health Care Flexible Spending Account or Dependent Care Flexible Spending Account Benefit Programs prior to Your termination (or loss of eligibility), You will have Your participation in these Benefit Programs reinstated according to your prior elections and prior payroll period contribution amount as of the first of the month following the date You are rehired (or again become eligible for benefits).

If You are rehired by Luxottica North America (or again become eligible for benefits) in a subsequent calendar year that is within 13 weeks after Your most recent employment with Us (or Your most recent eligibility) ended, and You participated in the Plan's Health Care Flexible Spending Account or Dependent Care Flexible Spending Account Benefit Programs prior to Your termination (or loss of eligibility), You will be treated as a newly hired Associate, unless you were rehired within 30 days after your termination (or loss of eligibility) . If You are treated as a newly hired Associate, Your participation and prior elections in these Benefit Programs will not be reinstated and You again will have to satisfy the Plan's waiting periods before becoming a Participant.

**6. Employment Of Family Members.**

If You and one or more of Your Family Members are employed by Luxottica North America, the following rules apply.

a. You cannot be covered as both an Associate and a Family Member.

b. A Dependent Child cannot be covered as a Dependent of more than one Associate.

7. **Limitation Of Enrolled Adults.**
You can only enroll one adult, other than Yourself, as a Spouse or Dependent. For example, if Your Spouse is enrolled You cannot enroll Your parent as a Dependent.

8. **Taxable Income.**
If a person who You are covering under the Plan's medical, dental or vision coverages is a Domestic Partner (including through a civil union) or is a Household Dependent, Luxottica North America may be required to include certain amounts of premium payments in Your taxable income. Please contact the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD if You have additional questions. These Family Members are eligible for Plan coverage as provided in the ***Eligibility*** section of this SPD.

## Enrollment Procedures

Before making Your benefit elections, You should carefully review this SPD, and if You have questions, please call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

You **must properly complete** the following enrollment procedures before the date that Your coverage is supposed to become effective. If You don't comply with the enrollment procedures in a timely manner, You will not be enrolled in the Plan. You can revoke Your election to enroll in the Plan any time prior to the date a Benefit Program's coverage becomes effective. To enroll in the Plan, You must complete the following steps.

1. **Full-Time Associates.**
   a. Go to www.LuxotticaBenefits.com and follow the instructions to complete the enrollment process.

   b. Print Your online enrollment benefit election confirmation so that You have proof of Your elections. If there is a dispute, You must provide the Luxottica Human Resources Service Center with a copy of Your confirmation form for the dispute to be investigated.

To enroll a person as a Dependent in the Plan, You will be required to provide proof of Your relationship with that person after You complete the enrollment process. You will also be required to provide proof of Your relationship during any Dependent audit to retain plan coverage.

2. **Part-Time Associates.**
Go to www.LuxotticaBenefits.com and follow the instructions to complete the enrollment process.

To enroll a person as a Dependent in the Vision Plan, You will be required to provide proof of Your relationship with that person after You complete the enrollment process. You will also be required to provide proof of Your relationship during any Dependent audit to retain plan coverage.

## Surcharges And Paying For Coverage

1. **Surcharge For Spouses, Domestic Partners And Household Dependents Who Have Other Employer Coverage Available.**
   If You are covering a Spouse, Domestic Partner or Household Dependent under one of the Plan's medical options and Your Spouse, Domestic Partner or Household Dependent is eligible to be covered under another employer's medical plan, a surcharge will be added to the normal premiums. The surcharge does not apply if your Spouse, Domestic Partner or Household Dependent also works for Luxottica. For Associates who are paid weekly, the surcharge is $25 per pay period. For biweekly paid Associates, the surcharge is $50 per pay period.

2. **Tobacco User Surcharge.**
   A Tobacco User surcharge will be added to the normal premiums that are required to be paid for coverage under the Plan's medical options. The surcharge applies to Associates (except those employed by Luxottica North America in Hawaii), Spouses, Domestic Partners and Household Dependents. If You believe You are unable to certify that You will be tobacco free for 2015, call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD and we will work with You (and, if You wish, with Your doctor) to develop another way to avoid the surcharge.

   For Associates who are paid weekly, the surcharge is $7.50 per pay period for each of the Covered Family Members described in the previous paragraph who is a Tobacco User. For biweekly paid Associates, the surcharge is $15 per pay period for each adult Covered Family Member described in the previous paragraph who is a Tobacco User.

   A Tobacco User is an adult who has used cigarettes, pipes, cigars, e-cigarettes or smokeless tobacco products anytime during the past six months (no matter how infrequently). In other words, You must be completely tobacco-free for six months to be exempt from the Tobacco User surcharge.

   If a former Tobacco User has been tobacco-free for six months, You can call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD to have the Tobacco User surcharge removed for **FUTURE** pay periods only. If You, or a Covered Family Member, has been tobacco-free for at least six months and You forget to call and notify the Luxottica Human Resources Service Center, You **WILL NOT** receive a refund for past surcharges under any circumstances.

3. **Paying For Coverage.**
   Unless otherwise specifically provided, eligible Associates generally may only pay for the cost of certain coverages through pre-tax salary reduction contributions. This Plan feature is described in the ***Section 125 Benefits, Flexible Spending Accounts and Health Savings Account*** section of this SPD.

Luxottica North America has the right to change, increase, or decrease Your contributions and/or premiums at any time.

Tax rules are complex and affect Associates differently. Since We don't know Your circumstances, We can't guarantee any tax result with respect to Your participation in the Plan. You are responsible for understanding how the tax rules apply. We suggest You consult with a tax advisor.

**Termination Of Plan Coverage**

Unless You are eligible for continuation coverage (as described in the ***Continuation Of Plan Coverage*** and ***COBRA*** sections of this SPD), coverage under the Plan's programs terminates for You and Your Family Members on midnight of the date the earliest of the following occur, unless otherwise provided by the Plan Administrator. Keep in mind that only a few of these events will make You eligible for COBRA coverage as explained in the ***COBRA*** section of this SPD.

1. You or Your Covered Family Members' coverage voluntarily or involuntarily terminates.

2. You and/or Your Covered Family Members are no longer eligible to participate (e.g., an individual is no longer Your Dependent, You are no longer a full-time Associate). You must notify the Luxottica Human Resources Service Center immediately if You or one of Your Covered Family Members is no longer eligible for the Plan. If anyone improperly receives benefits, they will be responsible for repaying the Plan, which may include reduction in Your other benefits and salary.

3. Your last day of employment with Luxottica North America. In this situation, Your Plan coverage ends on the last day of the period for which You paid premiums.

4. For an individual covered under the Plan pursuant to a severance arrangement, the date on which the severance arrangement provides that coverage under the applicable Benefit Programs ends.

5. You exhaust Your 6 months of short term disability benefits and You are not covered under the Plan's long term disability Benefit Program, unless otherwise determined by the Plan Administrator on an individual basis.

6. A Plan amendment makes You or Your Covered Family Members ineligible.

7. The Luxottica North America entity which employs You no longer participates in the Plan.

8. You fail to pay the required contributions, or premiums, for the cost of coverage under any Benefit Program in a timely manner (considering any applicable grace periods). Failure to pay Your share of the premium for any Benefit Program coverage will result in the termination of all of Your Benefit Program coverages, including those for which Luxottica North America pays the entire premium and those for which You are current on Your premiums.

9. As part of a dependent audit, or any through any other means, it is discovered that one of the individuals who You are covering under the Plan is not eligible for coverage. In this situation, Luxottica North America may terminate the Plan coverage prospectively, or retroactively if there has been fraud or an intentional misrepresentation. If Plan coverage is terminated retroactively, it would be considered a Rescission and Luxottica North America would provide 30 days' advance notice of the retroactive termination.

10. You, Your Family Members, or someone acting on behalf of You or Your Family Members, attempts to defraud the Plan or makes an intentional misrepresentation. In this situation, Luxottica North America may terminate the Plan coverage prospectively or retroactively. If Plan coverage is terminated retroactively, it would be considered a Rescission and Luxottica North America would provide 30 days' advance notice of the retroactive termination.

11. The Plan terminates, or one or more of its programs terminate.

## Continuation of Plan Coverage

### FMLA Leaves Of Absence

**1. Coverage.**
You may elect to continue coverage under all the Plan's Benefit Programs for which You are eligible (except for Dependent Care Flexible Spending Account coverage) during a Leave Of Absence that is subject to the Family and Medical Leave Act of 1993 ("FMLA"). To be eligible for the leave, You must have worked at least 1,250 hours for Luxottica North America during the past 12 months.

**2. Paying For Coverage.**
If coverage is elected, You will have to pay the premiums that similarly situated actively employed Associates pay in a timely manner. If You were paying the premiums on a pre-tax basis prior to Your leave, the pre-tax payments may continue if You are on paid leave. If You are not on paid leave, You must pay the premiums on an after-tax basis unless otherwise permitted by applicable law and Luxottica North America.

**3. Termination Of Coverage.**
Coverage may be continued until the earlier of the following events.

a. The end of the leave.

b. You give notice to Luxottica North America that You don't intend to return to work at the end of the leave.

c. The occurrence of any of the events described in the portion of the ***Enrollment And Participation*** section of this SPD that describes the termination of Plan coverage.

If coverage terminates as the result of a Qualifying Event, You and Your Covered Family Members may be eligible to continue Health Benefit Program coverage under COBRA as described in the ***COBRA*** section of this SPD.

## Military Leaves Of Absence

1. **Coverage.**
   You may elect to continue coverage under the Benefit Programs (as described in a and b below) during a military Leave Of Absence that s covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

   a. **First 30 Days Of Your Leave.** During the first 30 days of Your military leave, You may elect to continue coverage under all the Plan's Benefit Programs for which You are eligible (except for Dependent Care Flexible Spending Account coverage). If coverage is elected, You will have to pay (on an after-tax basis) the premiums similarly situated actively employed Associates pay in a timely manner.

   b. **After 30 Days Of Leave.** After the 30th day of Your military leave, You may only elect to continue Your medical, dental, vision, Health Care Flexible Spending Account and employee assistance Benefit Program coverage for up to 24 months to the extent You are eligible to participate in those programs. If coverage is elected, You will have to pay (on an after-tax basis) the Total Contribution Amount plus a 2% administrative fee.

   c. **Limitation On Benefits.** Even if You elected Plan coverage, the Plan will not pay benefits related to any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service.

2. **Termination Of Coverage During The Leave.**
   Coverage may be continued until the earlier of the following events.

   a. 24 months after Your military leave begins.

   b. The day after You fail to timely apply for (or return to) employment with Luxottica North America in accordance with USERRA.

   c. The occurrence of any of the events described in the portion of the ***Enrollment And Participation*** section of this SPD that describes the termination of Plan coverage.

   You and Your Covered Family Members may be also eligible to continue Health Benefit Program coverage under COBRA as described in the ***COBRA*** section of this SPD.

   Your election to continue coverage under USERRA or COBRA during a military Leave of Absence is considered an election to continue coverage under both laws, and the continuation coverage which is most beneficial to You generally will apply. Continuation of coverage under both laws will run concurrently.

   If any of Your Covered Family Members independently elect to continue coverage while You are on a military Leave of Absence, the election is considered an election to continue coverage under COBRA.

For details, please call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

3. **Coverage Upon Returning To Luxottica North America After The Leave.**
   If You return to Luxottica North America after Your leave with USERRA guaranteed reemployment rights, Your Benefit Program coverage will be reinstated.

**Personal Leaves Of Absence**

1. **Coverage.**
   You may elect to continue coverage under all the Plan's Benefit Programs for which You are eligible (except for Dependent Care Flexible Spending Account coverage) if You are on a Leave Of Absence because of personal reasons, relocating, or caring for a Domestic Partner. A personal Leave of Absence will be initially approved for 30 days. Associates may get up to four 15-day extensions.

2. **Paying For Coverage.**
   If coverage is elected, You will have to pay the premiums that similarly situated actively employed Associates pay in a timely manner. If You were paying the premiums on a pre-tax basis prior to Your leave, the pre-tax payments will continue if You are on paid leave. If You are not on paid leave, You must pay the premiums on an after-tax basis.

3. **Termination Of Coverage.**
   Coverage may be continued until the earlier of the following events.

   a. The date on which Your Leave Of Absence ends.

   b. The occurrence of any of the events described in the portion of the ***Enrollment And Participation*** section of this SPD describing the termination of Plan coverage.

   If coverage terminates as the result of a Qualifying Event, You and Your Covered Family Members may be eligible to continue Health Benefit Program coverage under COBRA as described in the ***COBRA*** section of this SPD.

**Disability Leaves Of Absence**

1. **Coverage.**
   If You become disabled (as determined under Luxottica North America's disability policies and procedures), You may elect to continue coverage under all the Plan's Benefit Programs for which You are eligible (except for Dependent Care Flexible Spending Account coverage).

2. **Paying For Coverage.**
   a. Hourly Associates. If coverage is elected, You will not have to pay anything other than the contributions to Your Health Care Flexible Spending Account or Your Health Savings Account if You: (i) are not eligible for short term disability benefits; and (ii) are not receiving disability payments

from the state or Workers' Compensation benefits. In all other situations, You will have to pay the premiums (on an after-tax basis) that similarly situated actively employed Associates pay in a timely manner.

b. Salaried Associates. If coverage is elected, You will have to pay the premiums that similarly situated actively employed Associates pay. If You were paying the premiums on a pre-tax basis prior to Your leave, the pre-tax payments will continue if You are on paid leave. If You are not on paid leave, You must pay the premiums on an after-tax basis.

**3. Termination Of Coverage.**
Coverage may be continued until the earlier of the following events.

a. The date on which You are no longer disabled.

b. You exhaust Your 6 months of short term disability benefits and You are not covered under the Plan's long term disability Benefit Program, unless otherwise determined by Luxottica North America on an individual basis.

c. The occurrence of any of the events described in the portion of the ***Enrollment And Participation*** section of this SPD that describes the termination of Plan coverage.

If coverage terminates as the result of a Qualifying Event, You and Your Covered Family Members may be eligible to continue Health Benefit Program coverage under COBRA as described in the **COBRA** section of this SPD.

### Extended Disability Leaves Of Absence

**1. Coverage.**
If You continue to be disabled (as determined under Luxottica North America's disability policies and procedures) at the end of Your disability Leave Of Absence, You and Your Covered Family Members may be eligible to continue Health Benefit Program coverage under COBRA as described in the **COBRA** section of this SPD.

## COBRA

### General

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires the Plan to offer Qualified Beneficiaries the opportunity to continue their coverage under the Health Benefit Programs after that coverage normally would have ceased. COBRA coverage is available for Qualified Beneficiaries only if a Qualifying Event occurs which results in a loss of Health Benefit Program coverage. COBRA coverage is generally identical to the Health Benefit Program coverage a Qualified Beneficiary had on the day before a Qualifying Event and to the coverage provided to similarly situated Participants who have not had a Qualifying Event. For purposes of applying the COBRA rules, the Plan may be treated as separate plans.

Health Care Flexible Spending Account COBRA coverage will only be offered to Qualified Beneficiaries who have "under spent" accounts. You have an under spent account if the annual amount You elected to contribute minus the amount of reimbursable claims You submitted up to the time of Your Qualifying Event is at least equal to the amount of COBRA premiums for Health Care Flexible Spending Account coverage for the remainder of the year. The "use it or lose it rule" will generally continue to apply, so any unused amounts in Your account at the end of the year will be forfeited, subject to the rules allowing carryovers (as interpreted by the Plan). Your COBRA coverage will also terminate at the end of the year.

Only Health Benefit Program coverages may be continued under COBRA.

**Notices Qualified Beneficiaries Must Provide**

After a Qualifying Event occurs, Qualified Beneficiaries must comply with the notice requirements described below to receive COBRA coverage.

If a Qualified Beneficiary does not comply with the notice requirements, all COBRA rights will be lost.

1. **Divorce, Legal Separation, Or Loss Of Dependent Status.**
   In the event of a Covered Associate's divorce or legal separation, or an individual's loss of Dependent status under the Plan, a Qualified Beneficiary must notify the Luxottica Human Resources Service Center within 60 days of the later of: (a) the date of the Qualifying Event; or (b) the date on which the Qualified Beneficiary would lose Health Benefit Program coverage because of the Qualifying Event.

2. **Second Qualifying Events.**
   In the event a Qualified Beneficiary is already receiving COBRA coverage under the Plan, and the Covered Associate dies, becomes divorced or legally separated, or an individual loses Dependent status under the Plan, the Qualified Beneficiary must notify the Luxottica Human Resources Service Center within 60 days after the later of: (a) the date of the second Qualifying Event; or (b) the date on which the Qualified Beneficiary would lose Health Benefit Program coverage because of the second Qualifying Event.

3. **Disability.**
   A Qualified Beneficiary must notify the Luxottica Human Resources Service Center within 60 days of the later of: (a) the date the Social Security Administration determines a Qualified Beneficiary is disabled; (b) the date of the initial Qualifying Event; (c) the date on which the Qualified Beneficiary would lose Health Benefit Program coverage because of the initial Qualifying Event, and before the end of the 18-month period following the date of the Qualified Beneficiary's termination of employment, or reduction in hours, with Luxottica North America. A Qualified Beneficiary must also notify the Luxottica Human Resources Service Center when the Social Security Administration determines the disabled Qualified Beneficiary is no longer disabled. The notice must be provided to the Luxottica Human Resources Service Center within 30 days after the date of the Social Security Administration's determination.

4. **Coverage Under Medicare Or Another Group Plan.**
A Qualified Beneficiary must notify the Luxottica Human Resources Service Center if, after electing COBRA coverage, a Qualified Beneficiary becomes Entitled To Medicare or becomes covered under another health plan. The notice must be provided within 30 days of the date the other coverage becomes effective or, upon becoming Entitled To Medicare.

5. **Documentation Accompanying A Notice.**
While documentation may not be required at the time of enrollment, the Luxottica Human Resources Service Center may request documentation at a later date.

6. **Manner Of Providing Notice.**
   a. **Health Benefit Program Benefits.** For COBRA relating to Health Benefit Program benefits, You must give notice of the events described in 1 through 4 above by going to the applicable COBRA administrator's website, or by calling the applicable COBRA administrator. Please refer to the ***Contact Information*** section of this SPD for the applicable COBRA administrator's COBRA website and telephone number.

   b. **Notice Deadline.** You must provide the notice no later than the applicable due dates described above.

## COBRA Elections

1. **General.**
Health Benefit Program Benefits. For COBRA relating to Health Benefit Program benefits, a Qualified Beneficiary may only elect COBRA coverage by: (a) electing online; or (b) calling the COBRA administrator. Please refer to the ***Contact Information*** section of this SPD for the applicable COBRA administrator's website and telephone number. COBRA elections must be made no later than 60 days after the latest of the following: (a) the date on the COBRA election notice; or (b) the date Health Benefit Program coverage is lost due to a Qualifying Event.

If a Qualified Beneficiary doesn't properly elect COBRA, all COBRA rights will be lost.

2. **Trade Act Of 2002.**
Special COBRA rights apply to Qualified Beneficiaries who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under the Trade Act of 2002 ("Trade Act"). Those Qualified Beneficiaries are entitled to a second opportunity to elect COBRA for themselves and certain Family Members (if they didn't already do so), but only within a period of 60 days (or less), and only during the 6 months immediately after their Health Benefit Program coverage ends. If You think You qualify for Trade Act assistance and want additional information, please call the applicable COBRA administrator at the telephone number in the ***Contact Information*** section of this SPD, the Health Care Tax Credit Customer Contact Center (by calling 866-628-4282, or 866-626-4282 for TTD/TTY callers) or go to www.doleta.gov/tradeact/. Qualified Beneficiaries must call the applicable COBRA administrator promptly after qualifying for Trade Act assistance or they will lose their special COBRA rights. COBRA

coverage elected during the special second election period begins on the first day of the special second election period.

**Paying For COBRA Coverage**

1. **General.**
   Qualified Beneficiaries must pay the applicable Total Contribution Amount for their COBRA coverage plus a 2% administrative fee. If there is an extension of COBRA coverage due to disability, the administrative fee is increased to 50% unless the only persons who elect the disability extension are non-disabled Qualified Beneficiaries. The Plan Administrator may change the amount of required COBRA contributions in accordance with the Code and regulations as interpreted by the Plan Administrator.

2. **Payment Amount.**
   A Qualified Beneficiary will not be considered to have made a COBRA payment if his or her check is returned for insufficient funds or otherwise. The Plan will not accept a partial COBRA payment unless the amount of the shortfall is not more than the lesser of $50, or 10% of the amount required to be paid (an "Insignificant Amount"). In that situation, a Qualified Beneficiary will be notified of the appropriate period of time he or she has to make up the shortfall and to pay the remaining amount due. If the amount of a payment shortfall is more than an Insignificant Amount, the Qualified Beneficiary must pay the remaining amount by the normal payment due dates described below. Qualified Beneficiaries are responsible for ensuring that their COBRA payments are correct. Qualified Beneficiaries may call the applicable COBRA administrator at the telephone number in the ***Contact Information*** section of this SPD to confirm the correct amount of their COBRA payments. No claims will be processed until a Qualified Beneficiary properly elects, and pays for, COBRA coverage.

3. **First Payment.**
   A Qualified Beneficiary must make the first COBRA payment no later than 45 days after the date of his or her COBRA election. The first payment must cover the cost of COBRA coverage from the time the Qualified Beneficiary's Health Benefit Program coverage would have otherwise terminated, up through the end of the month before the month in which the Qualified Beneficiary makes his or her first payment.

4. **Other Payments.**
   After a Qualified Beneficiary makes his or her first COBRA payment, subsequent monthly COBRA payments are due on the first day of each coverage month. However, Qualified Beneficiaries will be given a 30-day grace period to make each monthly payment. The Plan will provide COBRA coverage as long as the payment for a coverage month is made before the end of the 30-day grace period. If a Qualified Beneficiary makes a monthly payment after its due date, but during the payment's 30-day grace period, his or her COBRA coverage will be suspended as of the payment's due date and then retroactively reinstated back to the payment due date when the payment is made. Any claim that a Qualified Beneficiary submits while his or her COBRA coverage is suspended may be denied and have to be resubmitted after COBRA coverage is reinstated.

5. **Method Of Payment.**

a. Health Benefit Program Benefits. For COBRA relating to Health Benefit Program benefits, You can pay for COBRA coverage by personal check, money order, cashier's check or direct debit from Your bank account. No cash or credit card payments will be accepted. Checks or money orders must be made payable to Luxottica North America, and You should put the name and account number (or social security number) of the covered person on each check or money order.

b. Sending Payments/Deadline. You may make a COBRA payment via U.S. mail or express delivery service. A payment must be postmarked (if mailed) or have a "proof of date sent" (if sent by express delivery), no later than the applicable payment due date described above. The Plan will not accept late payments and Your COBRA coverage will be terminated. Please refer to the ***Contact Information*** section of this SPD for the applicable COBRA administrator's address and telephone number.

**Disabled Qualified Beneficiaries**

1. **General.**
   In addition to the notice requirements described above, the following provisions apply to a Qualified Beneficiary whom the Social Security Administration determines to be disabled, and who is eligible for COBRA coverage because of a Covered Associate's termination of employment, or reduction in hours of employment, with Luxottica North America.

2. **Extended COBRA Coverage.**
   A disabled Qualified Beneficiary may elect to extend his or her COBRA coverage (and the coverage of all related non-disabled Qualified Beneficiaries) from 18 months to 29 months. The Qualified Beneficiary's disability must be determined (by the Social Security Administration) to be in existence within the first 60 days of his or her COBRA coverage. This extension of COBRA coverage to 29 months applies to all Qualified Beneficiaries who: (a) lost Health Benefit Program coverage due to a Covered Associate's termination of employment, or reduction in hours of employment, with Luxottica North America; and (b) elected COBRA coverage. Please keep in mind that the 50% administrative fee discussed above will apply.

3. **Termination Of Coverage.**
   Extended COBRA continuation disability coverage for all related Qualified Beneficiaries will terminate as of the later of: (a) the first day of the month that is more than 30 days after the Social Security Administration's determination that the formerly disabled Qualified Beneficiary is no longer disabled; or (b) the end of the COBRA coverage period that applies without regard to the disability extension.

## Children

A Child born to, adopted by, or Placed For Adoption with, a Covered Associate during the period of COBRA coverage, is a Qualified Beneficiary. The Child's COBRA coverage only begins when the Child is properly enrolled in the Health Benefit Programs and lasts for as long as COBRA coverage lasts for the Covered Associate's other Qualified Beneficiaries.

## Special Rules

1. **Past Due Premiums For Coverage Before COBRA Event.**
   If, on the day before a Qualifying Event, You owe past due premiums for Health Benefit Program coverage for You or Your Covered Family Members, no one will be eligible for COBRA coverage because there was no proper Health Benefit Program coverage on the day before the Qualifying Event. Even though You and/or Your Qualified Beneficiaries may receive a notice, or other communication, from the Plan that could indicate eligibility for COBRA, any COBRA coverage elected by You and/or Your Qualified Beneficiaries can be immediately cancelled by Luxottica North America.

2. **Plan For COBRA Purposes.**
   Luxottica North America may define the "plan" for COBRA purposes in any way it wishes without providing prior notice. Currently, the Health Care Flexible Spending Account Benefit Program is treated as a separate "plan" for COBRA purposes.

3. **Conversion Coverage.**
   If You and/or Your Qualified Beneficiaries have COBRA coverage under any of the Plan's Company Funded Health Benefit Programs, please be aware that there will be no conversion coverage available for anyone when COBRA coverage ends. If You and/or Your Qualified Beneficiaries have COBRA coverage under any of the Plan's Insured Health Benefit Programs, the extent to which conversion coverage will be offered by the Insurer depends on applicable state law. In no event will Luxottica North America ever offer any type of conversion coverage when COBRA coverage ends. If You have questions about conversion coverage following the end of COBRA coverage, You should contact the company that insures the option under which You have COBRA coverage.

## COBRA Coverage Periods

The maximum allowable COBRA coverage periods are described in the following chart.

| Qualifying Event | Coverage Periods |
|---|---|
| A Covered Associate's termination of employment (other than for gross misconduct), or reduction in hours of employment, with Luxottica North America. | Up to 18 months for the Covered Associate, and his or her Covered Family Members, from the date of the Qualifying Event. |
| A Covered Associate's death, Medicare entitlement, divorce or legal separation. | Up to 36 months for the Covered Associate's Covered Family Members from the date of the Qualifying Event. |
| Loss of Dependent status under the Plan. | Up to 36 months, for the former Dependent, from the date of the Qualifying Event. |
| A Qualified Beneficiary becomes disabled following a Covered Associate's termination of employment (other than for gross misconduct), or reduction in hours of employment, with Luxottica North America. | Up to 29 months from the date of the Qualifying Event for the disabled Qualified Beneficiary and related Qualified Beneficiaries. |
| **Health Care Flexible Spending Accounts.** COBRA coverage for Health Care Flexible Spending Accounts can last only until the end of the year in which the Qualifying Event occurred. | |
| **Second Qualifying Events.** In the event of a second Qualifying Event, in some cases COBRA coverage may be extended up to 36 months measured from the date of the first Qualifying Event. | |
| **Special Medicare Rule.** If a Covered Associate experiences a termination of employment (other than for gross misconduct), or reduction in hours of employment, with Luxottica North America less than 18 months after the date he or she became Entitled To Medicare, the maximum COBRA coverage period will be 36 months beginning on the date the Covered Associate became Entitled To Medicare. This 36-month COBRA coverage period applies only to the Covered Associate's Dependents. | |

**Termination Of COBRA Coverage**

COBRA coverage will end before the end of the periods described in the chart above if any of the following events occur.

1. COBRA premiums are not paid in a timely manner.

2. A Qualified Beneficiary becomes covered under another health plan, or Entitled To Medicare (except in certain bankruptcy situations), after electing COBRA coverage under the Plan. The Plan may retroactively cancel COBRA coverage and require reimbursement of all benefits paid after the date of commencement of coverage under Medicare or another group health plan.

3. A disabled Qualified Beneficiary recovers from his or her disability during the 11-month disability extension of COBRA coverage as discussed above.

4. Luxottica North America, and related companies, cease to provide group health plan coverage to Associates.

5. The occurrence of any of the events described in the portion of the ***Enrollment And Participation*** section of this SPD that describes the termination of Plan coverage, if applicable.

## Medical Benefit Program

This SPD briefly summarizes the medical Benefit Program.
The specific provisions are contained in the applicable Benefits Booklets.

**General Information**

1. **Full-Time Options.**
   The Plan's medical Benefit Program consists of various Company Funded PPOs ,a high deductible health plan ("HDHP"), an Insured PPO and an HMO options. The HDHP option which allows You to make pre-tax contributions to a Health Savings Account ("HSA") if You are otherwise eligible and have no other disqualifying health insurance coverage. Benefits under the Company Funded options are paid for by Luxottica North America and benefits under the Insured options are paid for by the applicable Insurer.

2. **Full-Time PPO Options.**
   The PPOs are generally networks of physicians, pharmacies, hospitals, and other Providers who contracted with the Plan's Claims Administrators to provide health care at reduced rates to Participants. Those Providers are referred to as "In Network" Providers. The PPOs generally don't require You to use a specific Provider or choose a primary care physician. However, using In Network Providers will help to reduce Your costs for services. This is because the In Network Providers have agreed to provide services at reduced rates. If You want more information about the PPOs, please contact the applicable Claims Administrator listed in the chart in the ***Eligibility*** section of this SPD and request a copy of a Benefits

Booklet. You may contact the Claims Administrator at the telephone number or web address located in the ***Contact Information*** section of this SPD.

3. **Full-Time HMO Option.**
The HMOs offer managed care coverage. That means medical care can generally only be provided by Providers in the HMO network. You will be required to select a primary care physician and can only use Providers in the HMO network. Please be aware that only one geographic area has HMOs. If You want more information about the HMOs, please call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

4. **Full-Time HDHP Option.**
The high deductible health plan ("HDHP") coverage option is similar to the PPO options. However, the HDHP option has higher Deductibles, Out Of Pocket Maximums and lower premiums. You are generally responsible for 100% of the health care expenses (other than preventive care) for You and Covered Family Members until the Deductible and Out Of Pocket Maximum for the year are met. Once the Out Of Pocket Maximum is met, Covered Expenses will be paid by the Plan.

   If You enroll in the HDHP coverage option, You will be able to make pre-tax contributions to an HSA if You are otherwise eligible and have no other disqualifying health insurance coverage. If You are covered under the HDHP coverage option, You cannot make contributions to the Health Care Flexible Spending Account.

5. **General Differences Between The PPO, And HDHP Options.**
You should carefully consider the differences between available coverage options before making an enrollment decision.

   Your decision should be based on, among other things, Your medical needs, risk tolerance and affordability. HMOs typically provide more comprehensive coverage (e.g., no Deductibles, etc.) but premiums are generally higher. The HDHP Option has higher Deductibles and lower premiums.

6. **Full-Time GeoBlue Expatriate Option.**
The Plan also offers an Insured global benefits option for Full-Time Associates on international work assignment. If You are offered an international assignment, You will be provided with more information on this option.

7. **Part-Time Insured Options.**
If You are a Part-Time Associate, or Casual Part-Time Associate, You are not eligible for the benefits described in this section. Instead, You may enroll in the Part-Time Option, which is a separate Fixed Indemnity medical coverage option. You may also elect to purchase hospital indemnity coverage under the Part-Time Option. The Insurer listed in the chart in the ***Eligibility*** section of this SPD is solely responsible for paying for covered benefits provided to Participants. If You want more information on these options, please call the Insurer at the telephone number in the ***Contact Information*** section of this SPD and request a copy of the Benefits Booklets. NOTE: The Fixed Indemnity medical options do not satisfy the Affordable Care Act's requirement for most Americans to have Minimum Essential Coverage or face a tax penalty. See www.healthcare.gov for more information.

**8. Out Of Network Benefits.**

If You or a Family Members use an out of network provider, the Plan will generally pay a lesser amount of benefits than if an in network provider were used (regardless of the option chosen). Notwithstanding any contrary provision in a Benefits Booklets or any other document, contract or agreement (oral or written), the Insurer, Claims Administrator and/or Luxottica North America (as applicable) have the sole and absolute discretion to determine the amount of benefits payable under the Plan to an out of network provider. This discretion includes the absolute discretion to determine (and interpret) the methodology used to define or calculate out of network provider payments and the absolute discretion to interpret related terms and definitions (e.g., usual and customary, maximum permissible amount, etc.).

By accepting Plan benefits and choosing to have services provided by an out of network provider, an individual is entering into a separate agreement with the Plan in which he or she agrees: (a) to not assign his or her right to receive benefit payments to anyone, including an out of network provider; (b) that any reasonable method used by an Insurer, Claims Administrator's and/or Luxottica North America (as applicable) in accordance with their reasonable interpretation of the provisions in any Benefits Booklet (or similar documents) is acceptable and appropriate; and (c) to fully cooperate in protecting the Plan's rights and do nothing to prejudice those rights.

## Women's Health And Cancer Rights Act

The Plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Plan medical and surgical benefits. For any Deductible and/or Coinsurance amounts that apply, see the applicable Benefits Booklet for the medical coverage option under which You are covered. If You would like more information on these benefits, please call the applicable Claims Administrator, or Insurer, listed in the chart in the ***Eligibility*** section of this SPD at the telephone numbers in the ***Contact Information*** section of this SPD.

## Newborns' And Mothers' Act

Federal law prohibits the Plan (and medical Benefit Program Insurers) from: (1) restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section); and (2) requiring a Provider to obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Claims And Appeals Procedures

**1. Claims Administrators And Insurers.**

The Claims Administrators and the Insurers for the medical benefit options are listed in the in the chart in the ***Eligibility*** section of this SPD. The Claims Administrators for the Company Funded coverage options, and the Insurers for the Insured coverage options, have the authority to determine whether something is covered by the Plan.

2. **Filing Claims.**
Your Provider will usually file a claim with the Claims Administrator or Insurer for You. However, there may be situations when You must file Your claims (e.g., certain out of network services, etc.). Claims and appeals are administered in accordance with the provisions described in the applicable Benefits Booklet. If You would like a copy of a Benefits Booklet, or would like to file a claim, please call the applicable Claims Administrator, or Insurer, listed in the chart in the ***Eligibility*** section of this SPD at the telephone numbers in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the medical Benefit Program.

## Vision Benefit Program

### General Information

1. **Eye Exam Benefits.**
   - For no Copay, each Participant can receive 1 basic vision exam (including dilation) per calendar year from a participating Provider.
   - Each Participant can receive 1 Optomap® Digital Retinal Imaging service per calendar year from a participating Provider.
   - If You are an Associate employed by Luxottica North America in San Francisco, You are eligible for specific vision benefits. If You would like more information on these benefits, please contact Luxottica North America's Benefits Department at the telephone number in the ***Contact Information*** section of this SPD.

   The vision Benefit Program is Company Funded which means Luxottica North America pays for the benefits provided to Participants. As described below, EyeMed Vision Care administers claims.

   To locate a participating Provider, please contact EyeMed Vision Care at the telephone number or web address provided in the ***Contact Information*** section of this SPD.

2. **Complimentary Eyewear Certificates.**
Covered Associates may receive an eyewear certificate: (a) on each employment anniversary date while employed by Luxottica North America; and (b) in other circumstances as determined by Luxottica North America and the Plan Administrator.

3. **Contact Lens Benefits.**

   Covered Associates (not including Associates employed by Luxottica North America in San Francisco) can receive up to $40 for a standard contact lens fit and follow up, or 10% off retail price for a premium contact lens fit and follow up, but only with an in-network provider. There are no out-of-network reimbursements. In addition, there is a $220 allowance for conventional contact lenses, plus 15% off of the balance over $250. For disposable contact lenses, there is $220 allowance, plus any balance over $220. If medically necessary, contact lenses are paid-in-full. The examination and contact lens benefits described above are available only once every 12 months.

**Claims And Appeals Procedures**

EyeMed Vision Care is the Claims Administrator. If You have questions, You may contact EyeMed at the telephone number or web address as provided in the ***Contact Information*** section of this SPD or on the back of Your EyeMed vision card. Claims and appeals under the vision Benefit Program are administered in accordance with the applicable provisions described in the ***Claims And Appeals Procedures*** section of this SPD.

**ERISA Rights**

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the vision Benefit Program.

## Dental Benefit Program

This SPD briefly summarizes the dental Benefit Program.
The specific provisions are contained in the applicable Booklets.

**General Information**

1. **Full-Time Options.**
   The Plan's dental Benefit Program consists of a Company Funded PPO option and an Insured DMO option. Benefits under the Company Funded option are paid for by Luxottica North America and benefits under the Insured option are paid for by the applicable Insurer.

2. **Full-Time PPO Option.**
   The PPO option is generally a network of Dentists who contracted with the Plan's Claims Administrator to provide dental care at reduced rates to Participants. The PPO generally doesn't require You to use a specific Dentist or choose a primary care Dentist. However, using In Network Dentists will help to reduce Your costs. If You want more information on the PPO, please contact the applicable Claims Administrator listed in the chart in the ***Eligibility*** section of this SPD and request a copy of a Benefits Booklet. You may contact the Claims Administrator as provided in the ***Contact Information*** section of this SPD.

3. **Full-Time DMO Option.**
The DMO is an Insured managed care coverage option. That means dental care can generally only be provided by Dentists in the DMO network. Also, You will be required to select a primary care Dentist. Please be aware that some geographic areas may not have the DMO. If You want more information on the DMO, please contact the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD and request a copy of a Benefits Booklet. You may contact the Insurer as provided in the ***Contact Information*** section of this SPD.

4. **General Differences Between The PPO and DMO.**
You should carefully consider the differences between the coverage options before making an enrollment decision. Your decision should be based upon, among other things, Your dental needs, risk tolerance and affordability.

5. **Full-Time GeoBlue Expatriate Option.**
The Plan also offers an Insured global benefits option for Full-Time Associates on an international work assignment. If You are offered an international assignment, You will be provided with more information on this option.

6. **Part-Time Insured Option.**
If You are a Part-Time Associate, or Casual Part-Time Associate, You are not eligible for the benefits described in this section. Instead, You may enroll in the Part-Time Option, which is a separate Insured dental coverage option. The Insurer listed in the chart in the ***Eligibility*** section of this SPD is solely responsible for paying for covered benefits provided to Participants. If You want more information on this option, please call the Insurer at the telephone number in the ***Contact Information*** section of this SPD and request a copy of a Benefits Booklet.

## Claims And Appeals Procedures

1. **Claims Administrators And Insurers.**
The Claims Administrators and the Insurers for the dental benefit options are listed in the in the chart in the ***Eligibility*** section of this SPD. The Claims Administrators for the Company Funded coverage options, and the Insurers for the Insured coverage options, have the authority to determine whether something is covered by the Plan.

2. **Filing Claims.**
Your Dentist will usually file a claim with the Claims Administrator or Insurer for You. However, there may be situations when You must file Your claims (e.g., certain out of network services, etc.). Claims and appeals are administered in accordance with the provisions described in the applicable Benefits Booklet. If You would like a copy of a Benefits Booklet, or would like to file a claim, please call the applicable Claims Administrator, or Insurer, listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the dental Benefit Program.

## Section 125 Benefits, Flexible Spending Accounts and Health Savings Accounts

### General Information

The Plan generally allows eligible Associates to make pre-tax contributions to Flexible Spending Accounts or to Health Savings Accounts (as applicable) and/or pay Your portion of certain premiums on a pre-tax basis. Using pre-tax dollars reduces Your federal income and FICA taxes (and possibly state and local taxes) and increases Your take home pay. Since Your taxable income is reduced, there could be a reduction in Your Social Security benefits and/or benefits provided by Luxottica North America if those benefits are based on taxable income. However, the tax savings realized usually offsets reductions in other benefits.

You cannot elect to make contributions to a Health Care Flexible Spending Account if You are covered under the HDHP medical option.

If there is a problem with Your pre-tax premium elections, please call the Luxottica Human Resources Service Center immediately at the telephone number in the ***Contact Information*** section of this SPD. If it's determined that a refund of contributions is permitted, You may generally only get refunds if: (1) Your contributions were made during the current calendar year and within the 30 days prior to the time You notified the Luxottica Human Resources Service Center; and (2) You did not receive any benefits under the applicable coverage for period for which You are requesting a refund. If You had an employment status change (e.g., full-time to part-time or vice versa) within Luxottica North America, the date the change was entered into the HR system will be considered the applicable date benefits change.

You should consult with a tax advisor if You have any questions regarding the tax effects of participating in the Plan. We do not guarantee any specific tax consequences.

### Pre-Tax Premium Payment Feature

1. **Pre-Tax Payments.**
   Under the pre-tax premium payment feature, eligible Associates may pay their portion of premiums for certain coverages on a pre-tax basis. The Associates who are eligible, and the coverages for which premiums may be paid pre-tax, are described in the chart in the ***Eligibility*** section of this SPD. In general, eligible Associates can only pay for prospective coverage on a pre-tax basis unless there is a Qualified Status Change Event that involves the addition of a Dependent child through birth, adoption or Placement For Adoption. There may also be other limited circumstances in which premiums may be paid

on a pre-tax basis for retroactive coverage, as determined in the sole discretion of the Plan Administrator.

You may not pay for the cost of medical or dental coverage on a pre-tax basis for Your Household Dependent or Your Domestic Partner unless he or she is considered your tax dependent under IRS rules.

**2. Elections.**
When You first become eligible, You must make Your pre-tax premium payment elections. Your elections are irrevocable and will remain in effect unless You change them during an annual enrollment period, or in connection with a Qualified Status Change Event. However, Your pre-tax premium payment election will be automatically adjusted if Your share of premiums or costs change in an amount that is insignificant. The claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of this SPD do not apply to the Plan's pre-tax premium payment feature because it is not subject to ERISA. The Luxottica Human Resources Service Center's decisions with respect to the pre-tax premium payments are final and binding on all parties. You may not appeal a denial of a claim or adverse determination.

**Health Care Flexible Spending Account**

You cannot elect to make contributions to a Health Care Flexible Spending Account if You are covered under the HDHP medical option.

**1. Contributions.**

a. **Elections.** When You first become eligible, and during each annual enrollment period, You must make Your Health Care Flexible Spending Account contribution election. You may elect to contribute up to the IRS limit annually on a pre-tax basis. If You are married to an eligible Associate, each of You can contribute up to the IRS limit annually.

The minimum amount You can contribute to a Health Care Flexible Spending Account for a Plan Year is $130. To determine Your contribution for each pay period, divide the amount You elected to contribute for the calendar year by the number of pay periods in that year. If You enroll mid-year, be sure to only divide by the number of pay periods remaining in the Plan Year from Your coverage effective date (not Your hire date).

Your contribution elections only apply to the calendar year for which You made the election, and cannot be changed during the year unless You experience a Qualified Status Change Event. During the annual enrollment period, You will have to affirmatively elect how much You want to contribute (if anything) to a Health Care Flexible Spending Account for the following calendar year.

**b. Use It Or Lose It Rule/Carryovers.** Remember to plan carefully when deciding how much to contribute. The law generally requires that You lose any balance remaining in Your account at the end of the 90-day run-out period for the year. However, You are now permitted to carry over up to $500 of those unused amounts remaining in Your account and use those amounts for Qualifying Health Care

Expenses incurred during the following year if certain requirements. You must be Participant on the last day of the year (including a COBRA Participant) to be eligible to carry unused amounts over to the following year. You will lose any unused amounts over $500 in Your account at the end of the 90-day run-out period for a year (because amounts over $500 cannot be carried over). Also, unused amounts cannot be used for Dependent Care Expenses even if You also have a Dependent Care Flexible Spending Account. The Plan Administrator will determine how forfeited amounts will be used.

b. **Ordering rules for carryovers.**

c. **Leaves Of Absence.** If You go on a Leave Of Absence, the following rules apply.

- You can't change the amount of contributions elected for the year.
- You may continue making contributions.
- Qualifying Health Care Expenses incurred during Your leave are eligible for reimbursement.

  Upon returning from Your leave, Your contributions will restart at the amount You originally elected (unless You return in a later calendar year), or at an increased amount if You did not make contributions during Your leave.

**2. Health Care Expenses.**

a. **Qualifying Family Health Care Expenses.** You may only be reimbursed for Qualifying Health Care Expenses that were incurred by You and Your Spouse, Domestic Partner or Dependents while You are a Participant and that are not reimbursed through other coverage. A Qualifying Health Care Expense is incurred when the Service (or item) related to the expense is provided, not when the expense is paid.

**Example:** If You prepay on May 1st for services that will be provided throughout May, the expense is not incurred until May 31st and cannot be reimbursed until after May 31st.

b. **Examples Of Qualifying Health Care Expenses.** The following are some examples of Qualifying Health Care Expenses which are eligible for reimbursement if incurred during the calendar year. Please note that some of the following items must be accompanied by an authorized doctor's referral for treatment of a specific condition.

- Ambulances.
- Acupuncture.
- Artificial limbs and teeth.
- Automobile modification for the disabled.
- Back support devices.
- Braille books and magazines.
- Chiropractor.
- Contact lenses and maintenance.
- Cosmetic surgery (if Medically Necessary).
- Crutches.

- Deductibles, Copays and Coinsurance for the medical/dental Benefit Programs.
- Dental and orthodontia expenses.
- Eyeglasses.
- Family counseling.
- Hearing devices and equipment.
- Hospital bills.
- Laser eye surgery.
- Nursing care.
- Orthopedic shoes (excess cost over normal shoes).
- Medicine or drug that is insulin, or that requires a prescription or is available without a prescription but the individual has a prescription.
- Oxygen equipment.
- Podiatry services.
- Prescription drugs.
- Rental of medical equipment (with doctor's note).
- Routine checkups and physicals.
- Seeing eye dogs.
- Special education.
- X-rays.

c. **Examples Of Non-Qualifying Health Care Expenses.** The following are some examples of expenses that are not Qualifying Health Care Expenses, which means they are not eligible for reimbursement.

- Athletic club dues to keep fit.
- Babysitting.
- Cosmetic surgery (if not Medically Necessary).
- Diaper service.
- Funeral and burial expenses.
- Health insurance premiums.
- Marriage counseling.
- Maternity clothes.
- Trips to boost morale.
- Vitamins not prescribed by a doctor.

If You have questions about Qualifying Health Care Expenses, please call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

d. **Amount Available For Reimbursement.** The entire amount You elected to contribute for a calendar year (minus prior reimbursements made during the year) is available to reimburse You for Qualifying Health Care Expenses. Also, as noted above, You are now permitted to carry over up to $500 of unused amounts remaining in Your account and use those amounts for Qualifying Health Care Expenses incurred during the following year if certain requirements are met. See the "Use It Or Lose It Rule/Carryovers" section for more information.

e. **Termination Of Employment.** If Your employment with Luxottica North America terminates, the following rules apply.

- If You don't elect COBRA with respect to Your Health Care Flexible Spending Account, You can only submit claims for Qualifying Health Care Expenses incurred prior to Your termination of employment.
- If You elect COBRA with respect to Your Health Care Flexible Spending Account, You can submit claims for Qualifying Health Care Expenses incurred through the end of Your COBRA coverage period.

**3. Paying For Qualifying Health Care Expenses.**

a. **Direct Payment Or Reimbursement.** Your Qualifying Health Care Expenses will either be paid directly when You use Your flexible spending benefit card, or You can request a reimbursement as described in b below. If You request a reimbursement, You must include documentation of the expenses (e.g., receipts, explanation of benefits forms, etc.). If You use Your flexible spending benefit card to pay an expense, You don't have to submit expense documentation. However, You should keep the documentation because You may have to provide proof of the expenses if You are audited by the IRS or if the Luxottica Human Resources Service Center requests the information.

b. **Requesting Reimbursements.** You can request a reimbursement in either of the following ways.

- Go to the www.LuxotticaBenefits.com and complete the required personal and claim information. A claim sheet with an individualized bar code will be generated. You must print the claim sheet and then either fax or mail the claim sheet, and supporting documentation, to the Luxottica Human Resources Service Center's Flexible Spending Account address, or fax number. You may also electronically upload the form and supporting documentation. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account website, fax number and address.

- Call the Benefit Service Center and they will enter Your personal and claim information into the system for You. The Luxottica Human Resources Service Center will then mail You a claim sheet with an individualized bar code. You must either fax or mail the claim sheet, and supporting documentation, to the Luxottica Human Resources Service Center's Flexible Spending Account address or fax number. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account fax number and address.

c. **Deadline For Requesting Reimbursements.** Your properly completed claim form must be postmarked (if mailed), or received by fax or upload, no later than March 31following the end of the Plan Year during which the Qualifying Health Care Expense was incurred. However, if Your employment with Luxottica North America terminates, Your properly completed claim form must be postmarked (if mailed), or received by fax or upload, no later than 90 days following Your termination. Claims submitted after the deadline are not eligible for reimbursement.

d. **Reimbursement.** If the Luxottica Human Resources Service Center determines You are entitled to a reimbursement, it will be mailed to Your home address, or You can request to have the reimbursement direct deposited into Your bank account by calling the Luxottica Human Resources Service Center, or going to the Luxottica Human Resources Service Center's Flexible Spending Account website, and providing the necessary information. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account website and telephone number.

**If You want to appeal the Luxottica Human Resources Service Center's decision, please follow the appeals procedures described in the *Claims And Appeals Procedures* section of this SPD.**

4. **COBRA.**
The Health Care Flexible Spending Account Benefit Program is treated as a separate "plan" for COBRA purposes. If a Qualifying Event occurs, Qualified Beneficiaries may elect COBRA with respect to their Health Care Flexible Spending Account only if there is a positive account balance at the time of the Qualifying Event. If a Qualified Beneficiary elects COBRA, he or she must pay the monthly contribution amounts that he or she elected, plus a 2% administrative fee. Contributions can only be made on an after-tax basis. If You have questions, please review the ***COBRA*** section of this SPD or call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

**Dependent Care Flexible Spending Account**

1. **Contributions.**
You can only elect to make contributions to a Dependent Care Flexible Spending Account if You and Your Spouse are both employed and/or seeking employment.

a. **Elections.** When You first become eligible, and during each annual enrollment period, You must make Your Dependent Care Flexible Spending Account contribution election. You may elect to contribute up to $5,000 annually (per household) on a pre-tax basis subject to the following limitations: (i) if You aren't married and earn less than $5,000 during a calendar year, Your annual contribution amount is generally limited to Your earnings; (ii) if You're married and Your Spouse also works, a single $5,000 annual limit applies to both of You for the calendar year; (iii) if Your Spouse earns less than $5,000 during a calendar year, the maximum amount You can contribute together for the calendar year is limited to Your Spouse's income; and (iv) if You and Your Spouse file separate federal tax returns, the maximum You can contribute for the calendar year is $2,500.

The minimum amount You can contribute to a Dependent Care Flexible Spending Account for a Plan Year is $130. To determine Your contribution for each pay period, divide the amount You elected to contribute for the calendar year by the number of pay periods in that year. If You enroll mid-year, be sure to only divide by the number of pay periods remaining in the Plan Year from Your coverage effective date (not Your hire date).

Your contribution elections only apply to the calendar year for which You made the election, and cannot be changed during the year unless You experience a Qualifying Status Change Event. Each Year during the annual enrollment period, You will have to affirmatively elect how much You want to contribute (if anything) to a Dependent Care Flexible Spending Account for the following calendar year.

b. **Use It Or Lose It Rule.** Remember to plan carefully when deciding how much to contribute. The law requires that You lose any balance remaining in Your account at the end of a calendar year. Unused amounts cannot be used for Qualifying Health Care Expenses even if You also have a Health Care Flexible Spending Account. The Plan Administrator will determine how forfeited amounts will be used.

c. **Leaves Of Absence.** If You go on a Leave Of Absence, the following rules apply.

- You can't change the amount of contributions You elected for the year.
- Your contributions will stop.
- Dependent Care Expenses incurred during Your leave are not eligible for reimbursement.
- Upon returning from Your leave, Your contributions will restart (unless You return in a later calendar year) at an increased amount to ensure that Your annual contribution election amount in contributed to Your account by the end of the year.

**2. Dependent Care Expenses.**

a. **Qualifying Dependent's Expenses.** You may only be reimbursed for Dependent Care Expense that were incurred to care for a Qualifying Dependent while You are a Participant. A Dependent Care Expense is incurred when the service related to the expense is provided, not when the expense is paid.

**Example**: If You prepay on May 1st for Dependent care that will be provided throughout May, the expense is not incurred until May 31st and cannot be reimbursed until after May 31st.

b. **Examples Of Dependent Care Expenses.** The following are some examples of Dependent Care Expenses eligible for reimbursement if incurred during the calendar year to care for a Qualifying Dependent.

- Care at certain licensed nursery schools, pre-school or day care centers.
- Certain day camps.

- Services from individuals who provide care in or outside Your home while You work (as long as You or Your Spouse, former spouse and Children under age 19 are not the providers).
- Household services related to the care of the elderly or disabled adults or Children who live with You and for whom You can claims a tax exemption.

c. **Examples Of Non-Dependent Care Expenses.** The following are some examples of expenses that are not Dependent Care Expenses, which means they are not eligible for reimbursement.

- Services provided by Your Spouse or former spouse.
- Services provided by Your child who is under age 19.
- Services provided by an individual whom You claim as a tax exemption.
- Nursing home or custodial care.
- Overnight camp expenses.
- Expenses incurred during a time period during which You are not working or seeking employment.
- Tuition expenses for the 1st grade on.
- Expenses claimed as a dependent care tax credit.

You can learn more about Dependent Care Expenses by reading IRS Publication 503. You can get a copy of this publication by going online at www.irs.ustreas.gov/formspubs/index.html. If You have questions, please call the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

d. **Amount Available For Reimbursement.** Only the amount contributed to Your Dependent Care Flexible Spending Account at any particular time (minus any reimbursements made during the calendar year) is available for reimbursements.

**Example:** Assume You incurred $1,000 of Dependent Care Expenses by the end of March of 2015, but You only contributed $800 to Your account at that time. Only $800 would be available for reimbursement (assuming there were no prior reimbursements made during the year). You would have to wait to submit the remaining $200 in Dependent Care Expenses until after You make more contributions.

e. **Termination Of Employment.** If Your employment with Luxottica North America terminates, You can only submit claims for Dependent Care Expenses incurred prior to Your termination of employment.

**3. Paying For Dependent Care Expenses.**

a. **Requesting Reimbursements.** You can request a reimbursement in either of the following ways.

- Go to the Luxottica Human Resources Service Center's Flexible Spending Account website and complete the required personal and claim information. A claim sheet with an individualized bar code will be generated. You must print the claim sheet and then either fax, upload or mail the claim sheet, and supporting documentation, to the Luxottica Human Resources Service Center's Flexible Spending Account address, or fax number. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account website, fax number and address.

- Call the Benefit Service Center and they will enter Your personal and claim information into the system for You. The Luxottica Human Resources Service Center will then mail You a claim sheet with an individualized bar code. You must either fax or mail the claim sheet, and supporting documentation, to the Luxottica Human Resources Service Center's Flexible Spending Account address or fax number. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account fax number and address.

b. **Deadline For Requesting Reimbursements.** Your properly completed claim form must be postmarked (if mailed), or received by fax or upload, no later than March 31 following the end of the Plan Year during which the Dependent Care Expense was incurred. However, if Your employment with Luxottica North America terminates, Your properly completed claim form must be postmarked (if mailed), or received by fax or upload, no later than 90 days following Your termination. Claims submitted after the deadline are not eligible for reimbursement.

c. **Reimbursement.** If the Luxottica Human Resources Service Center determines You are entitled to a reimbursement, it will be mailed to Your home address, or You can request to have the reimbursement direct deposited into Your bank account by calling the Luxottica Human Resources Service Center, or going to the Luxottica Human Resources Service Center's Flexible Spending Account website, and providing the necessary information. Please refer to the ***Contact Information*** section of this SPD for the Luxottica Human Resources Service Center's Flexible Spending Account website and telephone number.

The claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of this SPD do not apply to the Dependent Care Flexible Spending Account Benefit Program because it is not subject to ERISA. The Plan's decisions with respect to the Dependent Care Flexible Spending Accounts is final. You may not appeal a denial of a claim or adverse determination.

**4. COBRA.**

COBRA does not apply to Dependent Care Flexible Spending Accounts.

## ERISA Rights

The Plan's pre-tax premium payment feature, and the Dependent Care Flexible Spending Account Benefit Program are not subject to ERISA. However, since the Health Care Flexible Spending Account Benefit Program is subject to ERISA, the ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the Health Care Flexible Spending Account Benefit Program.

## Health Savings Accounts

You cannot elect to make contributions to a Health Savings Account unless You are covered by the HDHP medical option and You are otherwise eligible. Also, Health Savings Accounts are not a Benefit Program or part of the Plan.

1. **Contributions.**
   a. **Elections.** While employed by Luxottica North America, You can only make pre-tax contributions to a Health Savings Account ("HSA") if You are covered under the Plan's HDHP medical option and You are otherwise eligible under IRS rules. For example, if You have other disqualifying health plan coverage, You are not eligible to make HSA contributions.

   You can elect to make pre-tax contributions to an HSA up to the annual IRS limits. Luxottica North America will not make contributions to Your HSA.

   If You elect to make HSA contributions, an account will be set up in Your name with the designated HSA provider. When Your account balance reaches $1,000, You will be able to direct how the amounts in your HSA are invested among the investment alternatives offered by the HSA provider. Investment gains accumulate tax-free while they held in your HSA.

   After your employment with Luxottica North America ends, You can take Your HSA with You and continue making contributions if You are eligible under IRS rules. If You have questions about your HSA, please call the Luxottica Human Resources Service Center, Anthem or the HSA provider as provided in the ***Contact Information*** section of this SPD.

   IRS rules governing HSAs are complex and affect Associates differently. Since We don't know Your circumstances, We can't guarantee Your eligibility to contribute to an HSA or any tax result. You are responsible for understanding how the tax rules apply. We suggest You consult with a tax advisor.

   b. **No Use It Or Lose It Rule.** Any balance remaining in Your HSA at the end of each year can be carried over to the following year.

2. **Using Amounts In Your Health Savings Account To Pay For Health Care Expenses.**

   You can take distributions from Your HSA (tax-free) to pay for (or be reimbursed for) otherwise unreimbursed qualified medical expenses that were incurred by You, Your Spouse, Your Domestic Partner or Your tax dependents, after Your HSA was established.

   A qualified medical expense generally is an expense for the medical care (as defined by Code §213(d)) that is not reimbursed by insurance or other sources.

   If You have questions about distributions from Your HSA, please call the Luxottica Human Resources Service Center, Anthem or Chase bank at the telephone number in the ***Contact Information*** section of

this SPD.

**ERISA Rights**

The Plan's pre-tax premium payment feature, the Dependent Care Flexible Spending Account Benefit Program are not subject to ERISA. Health Savings Accounts are also not subject to ERISA . The Health Care Flexible Spending Account Benefit Program is subject to ERISA, thus, the ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the Health Care Flexible Spending Account Benefit Program.

## Life and AD&D Benefit Program

This SPD briefly summarizes the life and AD&D Benefit Program.
The specific benefit provisions are contained in the applicable Benefits Booklets.

**General Information**

1. **Full-Time Insured Option.**
   The life and AD&D Benefit Program protects You and Your Family Members if You die or lose certain limbs. The life and AD&D Benefit Program is Insured which means the Insurers listed in the chart in the ***Eligibility*** section of this SPD are solely responsible for paying for covered benefits provided to Participants.

2. **Part-Time Insured Option.**
   If You are a Part-Time Associate, or Casual Part-Time Associate, You are not eligible for the benefits described in this section. Instead, You may enroll in the Part-Time Option, which is a separate Insured basic life coverage option. The Insurer listed in the chart in the ***Eligibility*** section of this SPD is solely responsible for paying for covered benefits provided to Participants. If You want more information on this option, please call the Insurer at the telephone number in the ***Contact Information*** section of this SPD and request a copy of a Benefits Booklet.

**Full-Time Associate Life Insurance**

1. **Coverage Options.**

You are automatically covered under the basic option and are not permitted to opt out. Supplemental coverage is optional. The following chart describes the coverage options.

| Coverage Options | All Full-Time Associates |
|---|---|
| Basic | 1x base salary<br>(rounded to the next higher $1,000) |
| Supplemental | 1-5x base salary<br>(rounded to the next higher $1,000) |
| $10,000 Minimum<br>6x base salary up to $2 million maximum | |

2. **Beneficiaries.**
   You must designate a Beneficiary. If You don't designate a Beneficiary, death benefits will be paid to Your heirs in accordance with applicable laws. To designate Beneficiaries, You follow the online process on www.LuxotticaBenefits.com.

3. **Living Benefits.**
   In certain situations described in the applicable Benefits Booklet, You may be eligible for living benefits if You become terminally ill. This allows You to receive part of Your death benefits while You're alive.

4. **Waiver Of Premiums.**
   If Your employment with Luxottica North America terminates because of total disability and You satisfy the requirements described in the applicable Benefits Booklet, Your life insurance coverage will generally be continued for a certain period time and You may not have to pay premiums.

5. **Policy Conversion Rights.**
   If Your life insurance coverage terminates because You stop working for Luxottica North America, or because You are transferred to an ineligible class, You may have the right to convert Your coverage to an individual policy in accordance with the rules described in the applicable Benefits Booklet.

## Full-Time Associate AD&D Insurance

You may be entitled to the death and dismemberment benefits described in the applicable Benefits Booklet if You lose certain limbs.

## Full-Time Associate Spousal Life Insurance

1. **Coverage.**
   Spousal life insurance coverage is optional. The following chart describes the coverage options.

| Coverage Options | Coverage Amount |
|---|---|
| 1 | $5,000 |
| 2 | $10,000 |
| 3 | $15,000 |
| 4 | $20,000 |
| 5 | $30,000 |
| 6 | $50,000 |
| Maximum | Associate's Basic + Supp. Coverage Amounts |

2. **Beneficiary.**
   If coverage is elected, only You (the Associate) can be the Beneficiary.

3. **Policy Conversion Rights.**
   If Your Spouse's life insurance coverage terminates because Your insurance coverage stops, or because of divorce, Your Spouse may have the right to convert his or her coverage to an individual policy in accordance with the rules described in the applicable Benefits Booklet.

**Full-Time Associate Child Life Insurance**

1. **Coverage.**
   Child life insurance coverage is optional for Your Dependent Children. The following chart describes the coverage options.

| Coverage Options | Coverage Amount |
|---|---|
| 1 | $2,000 |
| 2 | $5,000 |
| 3 | $10,000 |
| Maximum | $2,000 for Children up to 6 months of age |

2. **Beneficiary.**
   If coverage is elected, only You (the Associate) can be the Beneficiary.

3. **Policy Conversion Rights.**

If Your Dependent Child's life insurance coverage terminates because Your insurance coverage stops, or because he or she is no longer eligible, only an adult Child may be able to convert his or her coverage to an individual policy in accordance with the rules described in the applicable Benefits Booklet.

### Coverage Rules/Exclusions and Questions

There are many rules and exclusions that apply to the life and AD&D coverage described above. You can learn more about these rules and exclusions by reading the applicable Benefits Booklet, or by calling the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD (or the Luxottica Human Resources Service Center) at the telephone numbers in the ***Contact Information*** section of this SPD.

### Claims And Appeals Procedures

1. **Claims Administrator.**
   The Insurers listed in the chart in the ***Eligibility*** section of this SPD are the Claims Administrator.

2. **Filing Claims.**
   Claims are administered in accordance with the provisions described in the applicable Benefits Booklets. If You or Your Beneficiary would like to get a copy of a Benefits Booklet, or file a claim, please call the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the life and AD&D Benefit Program.

## Short Term Disability Benefits

This SPD briefly summarizes the insured Short Term Disability Benefit Program. The specific provisions for that coverage are contained in the applicable Benefits Booklet.

### General Information

If You are a Part-Time Associate, or Casual Part-Time Associate, You are not eligible for the benefits described in this section. Instead, You may enroll in the Part-Time Option, which is a separate Insured short term disability coverage option. The Insurer listed in the chart in the ***Eligibility*** section of this SPD is solely responsible for paying for covered benefits provided to Participants. If You want more information on this

option, please call the Insurer at the telephone number in the ***Contact Information*** section of this SPD and request a copy of a Benefits Booklet.

Eligible Full-Time Associates may receive short term disability benefits under the Luxottica Short Term Disability Plan. Please see the summary plan description for that plan for more information or contact the Luxottica Human Resources Service Center at (866) 431-8484.

### Claims And Appeals Procedures

1. **Claims Administrator.**
   Claims are administered by the Claims Administrator and Insurer listed in the chart in the ***Eligibility*** section of this SPD.

2. **Filing Claims.**
   You may file a claim or appeal in accordance with the procedures described in the applicable Benefits Booklet. If You want a copy of a Benefits Booklet, please call the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD does apply to the Insured short term disability insurance coverage for Part-Time Associates.

## Long Term Disability Benefits

This SPD briefly summarizes the Long Term Disability Benefit Program.
The specific provisions are contained in the applicable Benefits Booklet.

### General Information

The long term disability Benefit Program provides You with income protection if You become totally disabled for at least 180 days. The long term disability Benefit Program is Insured by the Insurer listed in the chart in the ***Eligibility*** section of this SPD which means the Insurer is solely responsible for paying for covered benefits provided to Participants.

If You are a Part-Time Associate, or Casual Part-Time Associate, You are not eligible for the benefits described in this section.

If You are in salary band 7 or above (or an equivalent job grade as determined by Luxottica North America), please see the executive long term disability benefits summary plan description. The executive long term disability benefits are provided under the Plan even though they are described in a separate summary plan description.

## Benefits

1. **Coverage Options.**
   Long term disability insurance coverage is optional. The following chart describes the long term disability coverage options. However, please keep in mind that the amount of Your long term disability benefits are based on Your annualized base salary and are reduced by the amounts described in the applicable Benefits Booklet, such as the reductions for Social Security benefits (or other similar benefits) received by You and/or Your Dependents.

| Coverage Options | Maximum Benefits Before Reductions | Minimum Reduced Benefits |
|---|---|---|
| 40% of base salary | $5,000/month | Greater of $25 or 5% of unreduced benefit |
| 60% of base salary | $10,000/month | Greater of $50 or 10% of unreduced benefit |

2. **Maximum Benefit Duration.**
   Benefits may only be paid while You are totally disabled and only for the time period described in the applicable Benefits Booklet.

3. **Rehabilitation.**
   It's possible You would benefit by returning to work in a limited capacity. The Insurer will evaluate Your case. If You are a candidate for rehabilitation, Your benefits may be reduced as described in the applicable Benefits Booklet.

4. **Survivor Benefit.**
   If You die while receiving long term disability benefits, a lump sum payment may be made to Your eligible survivor as described in the applicable Benefits Booklet.

5. **Waiver Of Premiums.**
   You generally will not have to pay premiums for long term disability coverage while You are receiving long term disability benefits if You comply with the rules described in the applicable Benefits Booklet.

## Coverage Rules/Exclusions And Questions

There are many rules and exclusions that apply to the long term disability coverage described above. You can learn more about these rules and exclusions by reading the applicable Benefits Booklet, or by calling the

applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD, or the Luxottica Human Resources Service Center, at the telephone numbers in the ***Contact Information*** section of this SPD.

### Claims And Appeals Procedures

1. **Claims Administrator.**
   The Insurer listed in the chart in the ***Eligibility*** section of this SPD is the Claims Administrator.

2. **Filing Claims.**
   Claims are administered in accordance with the provisions described in the applicable Benefits Booklet. If You or Your Beneficiary would like to get a copy of a Benefits Booklet, or file a claim, please call the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** *portion* of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the long term disability Benefit Program.

## Employee Assistance Benefit Program

### General Information

The employee assistance Benefit Program provides licensed counselors who are specially trained to give an initial assessment, and in most cases, give the short term counseling needed to cope with Your concerns. When specialized help is required, the counselors will assist You in selecting the most appropriate choice of care. The following are some of the concerns for which counselors can provide assistance.

- Marital or family problems.
- Divorce and/or separation.
- Dealing with terminal illness.
- Grief that follows a death.
- Alcohol and/or drug problems.
- Elder care concerns.
- Stress.
- Job related issues.
- Maintaining a balanced life.
- Legal and financial issues.

The services You receive are confidential unless required by law to be disclosed. The employee assistance Benefit Program is Insured by the Insurer listed in the chart in the ***Eligibility*** section of this SPD which means the Insurer is solely responsible for paying for covered benefits provided to Participants.

## Benefits

The following services are offered at no cost to You.

1. **Free Counseling Sessions.**
   You can receive up to 3 counseling sessions with a licensed counselor per "concern" and an unlimited number of referrals.

2. **Legal And Financial Counseling.**
   In addition to the counseling sessions described in 1 above, You can receive a 30 minute consultation (face-to-face or over the telephone) with respect to legal or financial concerns (other than those relating to Luxottica North America or the Plan). If You decide to hire an attorney or financial advisor, ongoing services may be provided at a discount in certain situations.

3. **Self-Search For Child And Elder Care.**
   You can receive listings of care resources in Your area. For more information, You may call the employee assistance program Insurer listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

## Cost To Participants

There is no cost to Participants for the covered counseling sessions. Participants must pay for additional sessions received in accordance with the terms of the Plan's medical Benefit Program. Also, if a counselor refers You to another Provider (e.g., drug treatment center), You are responsible for paying for the services in accordance with the terms of the Plan's medical Benefit Program.

## Questions, Claims And Appeals

The Insurer administers the employee assistance Benefit Program. If You have questions, please call the employee assistance program Insurer listed in the chart in the ***Eligibility*** section of this SPD at the telephone number in the ***Contact Information*** section of this SPD.

The provisions in the ***Claims And Appeals Procedures*** section of this SPD apply if applicable.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the employee assistance Benefit Program.

This SPD briefly summarizes the business travel insurance Benefit Program.
The specific provisions are contained in the applicable Benefits Booklet.

## Business Travel Insurance Benefit Program

### General Information

The business travel insurance Benefit Program may provide You with certain benefits if You are injured or die as the result of an accident that occurs while You are traveling in connection with work. The business travel insurance Benefit Program is Insured which means the Insurer listed in the chart in the ***Eligibility*** section of this SPD is solely responsible for paying for covered benefits provided to Participants.

### Benefits

Benefits include the accidental death and dismemberment benefits described in the applicable Benefits Booklet.

### Coverage Rules/Exclusions And Questions

There are many rules and exclusions that apply to the business travel insurance coverage. You can learn more about these rules and exclusions by calling Luxottica North America's Risk Management Department at the telephone number in the ***Contact Information*** section of this SPD.

### Claims And Appeals Procedures

**1. Claims Administrator.**

The Insurer listed in the chart in the ***Eligibility*** section of this SPD is the Claims Administrator.

**2. Filing Claims.**

Claims are administered in accordance with the provisions described in the applicable Benefits Booklet. If You would like to get a copy of a Benefits Booklet, or file a claim, please call the applicable Insurer listed in the chart in the ***Eligibility*** section of this SPD at telephone number in the ***Contact Information*** section of this SPD.

### ERISA Rights

The ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD applies to the business travel insurance Benefit Program.

## Tuition Reimbursement Program

The tuition reimbursement benefits described in this section are not provided under the Plan. This Non-Plan Program is only described in this SPD for Your convenience.

### General Information

The tuition reimbursement program provides You with an opportunity to continue Your education during Your employment with Luxottica North America.

### Eligibility And Benefits

Full-Time Associates are eligible to participate in the program on the 1st of month following 30 Days Of Employment. You are not eligible to participate in the program if you are covered by a collective bargaining agreement (or similar agreement) between union representatives and Luxottica North America unless the collective bargaining agreement specifically requires program coverage.

The program reimburses eligible Associates for up to 100% of Eligible Expenses for receiving a grade of A or B, or 50% of Eligible Expenses for receiving a grade of C, in an Approved Course. For Pass/Fail Approved Courses, a "passing" grade qualifies for up to a 100% reimbursement. Reimbursements are limited to $5,250 a calendar year per Associate. Reimbursements are paid by Luxottica North America out of its general assets. The program is not funded through a trust, insurance or any other source.

Luxottica Retail North America Inc., along with the following affiliated participating employers, have adopted this program for their eligible Associates: (a) Luxottica U.S. Holdings Corp.; (b) Luxottica Sun Corp.; (c) Luxottica USA LLC; (d) EYEXAM of California, Inc.; (e) Luxottica North America Distribution LLC; (f) EyeMed Vision Care LLC; (g) glasses.com Inc.; (h) The Optical Shop of Aspen; (i) Sunglass Hut Trading, LLC; (j) LensCrafters International, Inc.; (k) Luxottica Retail Canada Inc.; and (l) Luxottica Canada Inc.

### Eligible Expenses

The purpose of the program is to reimburse You for Eligible Expenses for Approved Courses. Eligible Expenses include Your out of pocket tuition and lab fees determined after all financial aid is subtracted. Eligible Expenses do not include fees for books, tools, supplies, registration, travel, meals, lodging, tutoring and other related charges. An Approved Course is an Eligible Class or Eligible Degree Program that is approved by Luxottica North America.

## Program Rules And Procedures

1. **Prior Approval.**
   You must receive proper approval before a class begins in accordance with the following procedures.

   a. Log on to www.LuxotticaBenefits.com to print the pre-approval form.

   b. Your Regional General Manager (store Associates) or Director or above must pre-approve the entire degree program.

   c. Signed pre-approval form must be sent as outlined on the pre-approval form for final approval prior to the first day of the course.

2. **Class Scheduling.**
   a. All classes should be scheduled outside of Your normal working hours and should not interfere with Your job responsibilities.

   b. Classes that qualify as credits for continued ABO certification must be taken through in-hours programs where available.

Completion of an Approved Course doesn't guarantee You to continued employment, promotion or increased compensation with Luxottica North America.

## Reimbursements

1. **Review Of Requests.**

   Luxottica North America's Third Party Administrator will review requests for reimbursement and make a decision as soon as administratively practicable. You will be notified of the decision, and, if approved, will be sent a reimbursement within a reasonable period of time.

2. **Repayment.**

   You must repay a reimbursement as soon as possible if Luxottica North America notifies You that the amount was not properly reimbursable. Luxottica North America may deduct the amount You owe from Your paychecks and from other benefits due to You under the Plan or any other Luxottica North America plan or arrangement (to the extent permitted by law).

3. **Professional Development Programs.**

   Professional development programs specific to individual job/department may be reimbursed through Your department. Check with Your department's management for more information.

**4. Appeals.**

If a reimbursement request is not approved, You may appeal the decision to the Tuition Reimbursement Committee, whose decisions will be final.

**Administration**

Luxottica North America's Benefits Department, and the Tuition Reimbursement Committee, have complete authority and discretion to administer the program. They will have the powers necessary to exercise their authority and discharge their responsibilities. Their determinations, interpretations, rules, and decisions are conclusive and binding on all interested persons.

**Taxes**

If the requirements of Internal Revenue Code § 127 are satisfied, up to $5,250 a calendar year in program reimbursements are generally not taxable to You. Reimbursements may be subject to FICA Social Security and FUTA federal unemployment taxes. Tax treatment for purposes of state and local taxes will vary depending on where You reside.

We don't guarantee any particular tax consequences with respect to reimbursements. We encourage You to consult with a tax advisor if You have tax questions.

**No ERISA Rights**

The tuition reimbursement program is a Non-Plan Program that is not subject to ERISA. Therefore, the ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD does not apply to the program.

## Adoption Assistance Program

The adoption assistance benefits described in this section are not provided under the Plan. This Non-Plan Program is only described in this SPD for Your convenience.

**General Information**

The adoption assistance program is designed to provide monetary assistance with Qualified Adoption Expenses to eligible Associates who are adopting an Eligible Child. Only reasonable and necessary Qualified Adoption Expenses that are directly related to the adoption of an Eligible Child may be reimbursed under the program.

## Eligibility And Benefits

Full-Time Associates are eligible to participate in the program on the 1st of month following 30 Days Of Employment. You are not eligible to participate in the program if you are covered by a collective bargaining agreement (or similar agreement) between union representatives and Luxottica North America unless the collective bargaining agreement specifically requires program coverage.

The program reimburses eligible Associates for up to $5,000 in Qualified Adoption Expenses. The $5,000 maximum is a life-time reimbursement limit for each Associate. Reimbursements are paid by Luxottica North America out of its general assets. The program is not funded through a trust, insurance or any other source. Only Qualified Adoption Expenses related to the adoption of the Eligible Child may be reimbursed. The program will not pay third parties directly for expenses, and Qualified Adoption Expenses incurred in any unsuccessful attempt to adopt count towards the life-time limit.

Luxottica Retail North America Inc., along with the following affiliated participating employers, have adopted this program for their eligible Associates: (a) Luxottica U.S. Holdings Corp.; (b) Luxottica Sun Corp.; (c) Luxottica USA LLC; (d) EYEXAM of California, Inc.; (e) Luxottica North America Distribution LLC; (f) EyeMed Vision Care LLC; (g) glasses.com Inc.; (h) The Optical Shop of Aspen; (i) Sunglass Hut Trading, LLC; (j) LensCrafters International, Inc.; (k) Luxottica Retail Canada Inc.; and (l) Luxottica Canada Inc.

## Qualified Adoption Expenses

Only reasonable and necessary Qualified Adoption Expenses that are directly related to the adoption of an Eligible Child may be reimbursed under the program.

### Examples Of Items That Are Qualified Adoption Expenses

- Agency and placement fees
- Legal fees and court costs
- An Eligible Child's medical expenses incurred prior to the adoption
- Travel expenses (including expenses for meals and lodging)
- Immigration, immunization and translations fees
- Other expenses directly related to the adoption (as determined by Luxottica North America).

### Examples Of Items That Are Not Qualified Adoption Expenses

- Expenses incurred prior to January 1, 2007
- Expenses in excess of the program's $5,000 lifetime reimbursement limit
- Expenses incurred to adopt an ineligible individual, such as a Spouse's child
- Expenses incurred as part of a surrogate parenting arrangement
- Expenses reimbursed by another source
- Expenses that Luxottica North America determines are not qualified.

## Program Rules And Procedures

1. **Reimbursement Requests.**

   To be reimbursed for Qualified Adoption Expenses, You must complete a reimbursement form, in the form and manner as prescribed by the Plan Administrator. Once the form is properly completed, it should be e-mailed to Luxottica North America's Benefits Department as provided in the in the ***Contact Information*** section of this SPD along with the documentation necessary to substantiate the expenses.

2. **International Adoptions.**

   Special rules apply to international adoptions, which are those involving a child who is not a citizen or resident of the U.S. at the time the adoption process begins. IRS rules do not allow the program to reimburse You for Qualified Adoption Expenses related to an international adoption until the year in which the adoption is finalized.

## Reimbursements

1. **Review Of Requests.**

   Luxottica North America's Benefits Department will review requests for reimbursement and make a decision as soon as administratively practicable. You will be notified of the decision, and, if approved, will be sent a reimbursement within a reasonable period of time.

2. **Repayment.**

   You must repay a reimbursement as soon as possible if Luxottica North America notifies You that the amount was not properly reimbursable. Luxottica North America may deduct the amount You owe from Your paychecks and from other benefits due to You under the Plan or any other Luxottica North America plan or arrangement (to the extent permitted by law).

3. **Appeals.**

   If a reimbursement request is not approved, You may not appeal the decision.

## Administration

Luxottica North America's Benefits Department has complete authority and discretion to administer the program. It will have the powers necessary to exercise their authority and discharge their responsibilities. Luxottica North America's determinations, interpretations, rules, and decisions are conclusive and binding on all interested persons.

## Taxes

If the requirements of Code §137 are satisfied, up to $5,000 in program reimbursements are excludable from Your income. However, this exclusion begins to be phased out if Your federal modified adjusted gross

income for You and Your spouse exceeds $201,010 (in 2015), and is completely phased-out once income reaches $241,010 (in 2015).

Luxottica North America will not take federal income tax withholdings from Your reimbursements, but is required to withhold Social Security and Medicare taxes. Tax treatment for purposes of state and local taxes will vary depending on where You live.

We don't guarantee any particular tax consequences with respect to reimbursements. We encourage You to consult with a tax advisor if You have tax questions.

**No ERISA Rights**

The adoption assistance program is a Non-Plan Program that is not subject to ERISA. Therefore, the ***ERISA Rights*** portion of the ***General Plan Information And ERISA Rights*** section of this SPD does not apply to the program.

## Claims And Appeals Procedures

**General Information**

The following claims and appeals procedures apply to the employee assistance, Health Care Flexible Spending Account, vision, the voluntary benefits (to the extent covered by ERISA), and any other healthcare Benefit Program that does not provide for adequate claims procedures as determined by the Plan Administrator. You should first consult the applicable Benefits Booklet for the applicable claims and appeals procedures.

Please note that Paragraphs 1 and 3 of the ***Other Provisions*** portion of this section apply to all of the Plan's Benefit Programs and Non-Plan Programs.

The Plan Administrator, Claims Administrator and Appeals Committee (as applicable) are responsible for internally adjudicating benefit claims/appeals and for providing full and fair review of the claims/appeals in an independent and impartial manner. Unless otherwise provided in these procedures, a benefit claim/appeal must be in writing in a form acceptable to the Plan Administrator, Claims Administrator or Appeals Committee (as applicable). The procedures in this section only have to be followed if required by ERISA (as interpreted by the Plan Administrator). If a claim is submitted by a Provider who doesn't have recourse against a Participant for amounts not paid by the Plan, the procedures in the ***Provider Claims*** portion of this section will apply.

If a claim is submitted by a Claimant, or by a Provider who has recourse against a Claimant for amounts not paid by the Plan, the procedures described below apply (except for procedures described in this section regarding Provider claims). These procedures do not apply to disputes with Providers, Insurers or managed care organizations regarding payments that may be due to them, provided the resolution of the dispute has

no effect on Plan benefits, as determined in the sole and absolute discretion of the Plan Administrator (or Claims Administrator).

A claim or appeal is a written request (that clearly specifies that it is a claim or appeal) for Plan benefits filed with the Plan Administrator in accordance with the following procedures. If a claim is being filed by Your authorized representative, You must provide the Claims Administrator with a written authorization (that is acceptable to the Claims Administrator) which designates the person as Your representative.

There are four types of claims that can be made under the Plan. Each type of claim is subject to the following rules.

**Urgent Care Claims**

Urgent Care Claims are claims for benefits that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize a Claimant's life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of a Claimant's medical condition, could cause severe pain. The Plan Administrator (or Claims Administrator) will determine whether - something is an Urgent Care Claim. However, if a physician with knowledge of a Claimant's medical condition determines that a claim involves urgent care, it will be considered an Urgent Care Claim.

If a Claimant fails to provide information sufficient to determine whether benefits are payable under the Plan, the Plan Administrator (or Claims Administrator) will notify the Claimant, as soon as practicable, within 24 hours after it receipt of a proper claim, of the necessary information. The Claimant will be given a reasonable amount of time, but not less than 48 hours, to provide the necessary information. Once the Plan Administrator (or Claims Administrator) receives the additional information, the claim will be decided within 48 hours of the earlier of: (1) the Plan Administrator's (or Claims Administrator's) receipt of the additional information; or (2) the end of the period within which the Claimant had to provide the additional information.

If a Claimant fails to follow the Plan's claims procedures, the Plan Administrator (or Claims Administrator) will notify the Claimant of the Plan's proper procedures within 24 hours. The notification may be oral unless the Claimant requests otherwise.

The Plan Administrator (or Claims Administrator) will notify a Claimant of its decision on an Urgent Care Claim as soon as practicable, but no later than 72 hours after it received a proper claim regardless of whether it denies the claim. If the notice is provided orally, a written or electronic notice will be provided to the Claimant within 3 calendar days.

**Pre-Service Claims**

Pre-Service Claims are claims for benefits that require notification and approval prior to receiving medical care, unless it is an Urgent Care Claim. The Plan Administrator (or Claims Administrator) will notify a

Claimant of its determination within a reasonable time, but not later than 15 days after it received proper claim. This period may be extended for up to 15 days if the Plan Administrator (or Claims Administrator): (1) determines the extension is necessary due to matters beyond its control; and (2) notifies the Claimant before the end of the initial 15-day period of the circumstances requiring the extension and of the date by which it expects to make a decision. If an extension is necessary because a Claimant failed to submit the information necessary to decide the claim, the extension notice will specifically describe the necessary information, and the Claimant will be given at least 45 days from receipt of the notice within which to provide that information. If the necessary information is received by the Plan within the 45-day period, the Plan Administrator (or Claims Administrator) will notify the Claimant of its determination within 15 days of receiving all of the information. If a Claimant does not provide the necessary information within the 45-day period, the claim will be denied.

If a Claimant fails to follow the Plan's claims procedures, the Plan Administrator (or Claims Administrator) will notify the Claimant of the Plan's proper procedures within 5 days. The notification may be oral unless the Claimant requests otherwise.

**Post-Service Claims**

Post-Service Claims are claims for benefits that are filed after medical care has been received. A Claimant must file a proper Post-Service Claim within 90 days following receipt of the services, treatment or product to which the claim relates unless: (1) it was not reasonably possible to file the claim within that time frame; and (2) the claim is filed as soon as possible and in no event (except in the case of the Claimant's legal incapacity) later than 12 months after the date the of receipt of the service, treatment or product to which the claim relates.

The Plan Administrator (or Claims Administrator) will notify a Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after its receipt of a proper claim. This period may be extended for up to 15 days if the Plan Administrator (or Claims Administrator): (1) determines that the extension is necessary due to matters beyond their control; and (2) notifies the Claimant before the end of the initial 30-day period of the circumstances requiring the extension, and of the date by which it expects to make a decision. If an extension is necessary because a Claimant failed to submit the information necessary to decide the claim, the extension notice will specifically describe the necessary information, and the Claimant will be given at least 45 days from receipt of the notice within which to provide the necessary information. If the necessary information is received by the Plan within the 45-day period and the claim is denied, the Plan Administrator (or Claims Administrator) will notify the Claimant of the denial within 15 days after the information is received. If the Claimant does not provide the necessary information within the 45-day period, the claim will either be denied or the Plan's decision will be tolled from the date the extension notice is sent until the date the Claimant responds to the request for information.

## Concurrent Care Claims

Concurrent Care Claims are claims for benefits that request to approve an on-going course of treatment to be provided over a period of time or for a specified number of treatments. The two types of Concurrent Care Claims are when: (1) the reconsideration a previously approved claim results in a reduction or termination of that approved claim; or (2) a Claimant requests an extension of the treatment approved in a previous claim.

If a Claimant's request to extend treatment is an Urgent Care Claim, the Plan Administrator (or Claims Administrator) will make a determination as soon as possible, and will notify the Claimant of its decision within 24 hours after receiving a proper claim, provided the request was made at least 24 hours prior to the end of the previously approved period of time or treatment. If the request is not made within that 24-hour period, it will be treated as an Urgent Care Claim and decided in accordance with the procedures for deciding Urgent Care Claims. If the request is not an Urgent Care Claim, the request will be considered a new claim and decided according to the Post-Service Claim or Pre-Service Claim procedures as applicable. If the Plan Administrator (or Claims Administrator) decides to reduce or terminate a previously approved course of treatment (other than because of a Plan amendment or termination), the Plan Administrator (or Claims Administrator) will notify the Claimant sufficiently in advance of the reduction or termination to allow the Claimant to appeal the decision before the treatment is reduced or terminated.

## Provider Claims

Written proof of charges upon which a claim is based must be provided to the Plan Administrator (or Claims Administrator) within 90 days after the end of the Plan Year in which the charges were incurred (unless specifically approved by the Plan Administrator). If the Plan Administrator (or Claims Administrator) determines that it was not reasonably possible to provide written proof within 90 days after the end of the Plan Year (or other period specified by the Plan Administrator), the Plan Administrator (or Claims Administrator) will not reduce the claim for that reason if the proof is provided as soon as reasonably possible. Notwithstanding the forgoing, proof of charges must be provided to the Plan no later than one year from the date on which the charges were incurred unless otherwise specifically approved by the Plan Administrator (or Claims Administrator).

## Claims Denials And Other Adverse Determinations

If the Plan Administrator (or Claims Administrator) denies a claim or makes another decision that's considered an adverse benefit determination under Department of Labor claims regulations (as interpreted by the Plan Administrator), or there is a Rescission of an individual's Plan coverage, it will provide a Claimant with a notice, either in writing or electronically, containing the following information: (1) the specific reasons for the adverse action; (2) references to the specific Plan provisions on which the action was based; (3) a description of any additional information necessary for the Claimant to complete the claim, and an explanation why the information is necessary; (4) if the Plan Administrator (or Claims Administrator) relied on an internal rule in making its decision, either a copy of the rule or a statement that the rule was relied upon and that the Claimant can request a copy of the rule free of charge; (5) if the Plan Administrator (or

Claims Administrator) based its decision on a medical necessity or experimental treatment or similar exclusion or limit, the notice will include a statement that the decision was based on this type of exclusion

and that the Claimant can request a copy (free of charge) of an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the Claimant's circumstances; (6) in situations involving urgent care, a description of the expedited review process; (7) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim; and (8) a description of the Plan's internal appeals, and external review, procedures, including a statement of the Claimant's right to bring a lawsuit under ERISA §502(a) if his or her appeal of the adverse action is denied. This means that a Claimant must first exhaust the Plan's internal appeals process (described below) before he or she can file a lawsuit with respect to an adverse action. In no event can a Claimant, or anyone else, file a lawsuit with respect to an adverse action more than 1 year after the Plan Administrator (or Claims Administrator) denied his or her internal appeal, as discussed in the ***Other Provisions*** portion of this section.

The decisions of the Plan Administrator and the Claims Administrator will be given the maximum deference permitted by law.

**Internal Appeals Procedures**

1. **General Procedures.**
   If a claim is denied, a Claimant has the right to an internal appeal. Claimants must submit an appeal to the Plan's designated appeals administrator (the "Appeals Committee") and will get a full and fair review of their claims in accordance with the following provisions.

   a. An appeal must generally be in writing and include the following information: (i) the Claimant's name and address; (ii) the date the Plan notified the Claimant that his or her claim was denied; and (iii) the reasons the Claimant is disputing the denial of his or her claim; and (iv) any relevant documentation or information that the Claimant has not already provided. Also, a Claimant may submit written comments, documents, records, testimony and other claim-related information.

      However, if a claim is for urgent care, a Claimant can request an expedited appeal by telephone, facsimile or electronically. An urgent care appeal should include at least the following information: (i) the Claimant's name; (ii) the Claimant's medical condition or symptom; (iii) the treatment, service or product being requested; and (iii) the reasons why the appeal should be expedited. The Appeals Committee's communications, including its decision, will be communicated to the Claimant by telephone, facsimile or electronically.

   b. An appeal must generally be made within 180 days following a Claimant's receipt of notice that his or her claim was denied, except that the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the ***Concurrent Care Claims*** portion of this section) must be made within 30 days of a Claimant's receipt of the notice that his or her previously approved course of treatment will be reduced or terminated. If a Claimant misses these deadlines, the

Claimant will lose his or her right to an appeal, an external review, and to file a lawsuit, with respect to an adverse decision on a claim.

c. The Appeals Committee consists of individuals who did not deny the original claim and who are not subordinate to the individuals that denied the claim. The Appeals Committee will not give deference to the original claim denial and will take into account all comments, documents, records, and other information submitted by a Claimant regardless of whether that information was previously submitted, or available at the time the initial claim was reviewed.

d. If the original claim was denied based on medical judgment, the Appeals Committee will consult with a health professional with appropriate training and experience. The health care professional will not be the same person who was consulted (if any) in connection with the denial of the original claim or be a subordinate of that individual.

e. Upon request and free of charge, the Claimant will be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

f. The Appeals Committee's decisions will be given the maximum deference permitted by law.

**2. Timing Of Appeals Decisions.**

a. Urgent Care Claims. The Appeals Committee will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after it receives a proper appeal.

b. Pre-Service Claims. The Appeals Committee will decide the appeal of a Pre-Service claim within a reasonable time but no later than 30 days after it received a proper appeal.

c. Post-Service Claims. The Appeals Committee will decide the appeal of a Post-Service claim within a reasonable time but no later than 60 days after it received a proper appeal.

d. Concurrent Claims. The Appeals Committee will decide the appeal of a decision by the Plan Administrator (or Claims Administrator) to reduce or terminate a previously approved course of treatment before the proposed reduction or termination takes place. The Appeals Committee will decide the appeal of a denied request to extend a previously approved course of treatment in accordance with the rules in a through c above which are appropriate for the appeal.

**3. Notice Of The Decision Of An Appeal**

The Appeals Committee will generally notify a Claimant in writing (or electronically) of its decision of his or her appeal regardless of whether the decision is adverse. If the decision is adverse, the notice to the Claimant will contain the following information: (a) the specific reasons for the denial; (b) reference to the Plan provisions on which the decision was based; (c) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim ; (d) if the Appeals Committee relied on an internal rule in making its determination, either a copy of the rule or a statement that the rule was relied upon and that the Claimant can request a copy of the rule free of charge; (e) if the Appeals

Committee based its decision on a medical necessity or experimental treatment or similar exclusion or limit, the notice will include a statement that the decision was based on this type of exclusion and that the Claimant can request a copy (free of charge) of an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the Claimant's circumstances; and (f) a statement of the Claimant's right to request an external review in certain circumstances or bring a lawsuit under ERISA §502(a). Notification of an adverse decision on an appeal of an Urgent Care Claim may be provided orally, but a written notice will be provide no later than 3 days after oral notice was provided.

## External Reviews

1. **General.**
   a. After exhausting the Plan's internal appeals process, a Claimant can choose to request an external review if the adverse decision is based on "medical judgment" (e.g., medical necessity) and not based on failing to satisfy the Plan's eligibility requirements. A Claimant can also request an external review of a Rescission after exhausting the Plan's internal appeals process. This process provides a Claimant with an independent review of a denied appeal by an independent review organization ("IRO"). The applicable Claims Administrator contracted with an IRO(s) in a manner intended to result in independent and unbiased external reviews. An IRO uses independent physicians who are qualified to decide whether a service or procedure is covered by the Plan and appropriate legal experts as necessary. An IRO will not meet with the Claimant, Plan Administrator, Claims Administrator or the Appeals Committee, and will not allow any of the parties to participate in its decision.

   b. A Claimant must generally request an external review in writing and may include any information or evidence that was not previously provided. The request must generally be made within the 4 months following a Claimant's receipt of an adverse determination on his or her appeal. If a Claimant misses this deadline, the Claimant will lose his or her right to an external review. The request should be sent to the Claims Administrator in the manner described in the Benefits Booklet for the coverage option under which the Claimant is covered.

   c. As soon as administratively practicable, the Claims Administrator will assign a Claimant's request for an external review to an IRO, and within 5 business days of the assignment, will forward the relevant medical records, and other information, that was relied upon during the Plan's internal claims and appeals process.

   d. Instead of a "Standard External Review," a Claimant can request an "Expedited External Review" if he or she received either: (i) a denial of an internal claim that involves a medical condition where the time for completing an expedited internal appeal would seriously jeopardize the Claimant's life or health or ability to regain maximum function, and the Claimant requested an expedited internal appeal; or (ii) a denial of an internal appeal that involves either, (A) a medical condition where the time for completing a standard external review would seriously jeopardize the Claimant's life or health or ability to regain maximum function, or (B) an admission, availability of care, continued

stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

e. An IRO's decision is binding on parties unless state or federal law provides other remedies for the Clamant and/or the Plan. This means that if no other legal remedies are available, a Claimant who decides to use the external reviews process will be giving up his right to bring a lawsuit in connection with an adverse determination.

**2. Timing Of Decisions.**

a. Preliminary Review By The Plan. For a Standard External Review, the Claims Administrator will make a preliminary determination of whether a request is eligible for external review (and whether a Claimant provided all necessary information and forms) within 5 business days of receiving a Claimant's request for an external review. The Claims Administrator will notify a Claimant in writing of its preliminary decision within 1 business day after completing the review. If a request is not eligible for an external review, the notice will explain why and will provide ***contact information*** for the Employee Benefits Security Administration. If a request is incomplete, the notice will describe missing information and forms. A Claimant must be provided the missing information and forms by the end of the 4 -month period described in 1b above, or if later, within 2 days of receiving the notice from the Claims Administrator.

For an Expedited External Review, the Claims Administrator will immediately make a preliminary determination of whether a request is eligible for external review (and whether a Claimant provided all necessary information and forms). The Claims Administrator will immediately notify a Claimant in writing of its preliminary decision. The notice will contain the same information as it would for a Standard External Review.

b. IRO's Acceptance Of A Request. For a Standard External Review, an IRO will notify a Claimant in writing, and in a timely manner, of whether a request for external review was accepted, that the Claimant can submit additional information in writing to the IRO within 10 business days following receipt of the notice, and that the IRO will consider the information when making its decision.

c. IRO's Final Decision Of An External Review. For a Standard External Review, an IRO will notify a Claimant, and the Plan, in writing of its final decision within 45 days after it received the Standard External Review request.

For an Expedited External Review, an IRO will notify a Claimant, and the Plan, of its final decision as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO received the Expedited External Review request.

**3. Notice Of An IROs Decision.**

An IRO will generally notify a Claimant and the Plan in writing (or electronically) of its decision on an external review regardless of whether the decision is adverse. The notice will generally contain the following information: (a) general description of the reason for the external review request; (b) the date the external review was assigned to the IRO and the date the IRO made its decision; (c) references to the evidence or documentation considered in reaching the decision, including specific coverage provisions

and evidence-based standards; (d) a discussion of the principal reasons for the decision, including the rationale and any evidence-based standards upon which the IRO relied; (e) a statement that the IRO's determination is binding, unless other remedies are available to the Plan or Claimant under state or federal law; and (f) a statement that judicial review may be available to the Claimant.

If the notice is not in writing with respect to an Expedited External Review, the IRO will provide the Claimant and the Plan a written confirmation of its decision within 2 days of providing the non-written notice.

## Other Provisions

1. **Legal Actions.**
   The provisions of this Paragraph apply notwithstanding any contrary provision of any Benefits Booklet or any other document or communication with respect to any of the Plan's Benefit Programs or Non-Plan Programs. No legal or similar action relating in any way to a claim for benefits under any of the Plan's Benefit Programs or Non-Plan Programs may be brought by, or on behalf of, any Participant or Claimant or their authorized representatives until the Plan's administrative remedies (the claims and appeals process described above) have been exhausted. The ability to file a lawsuit with respect to an adverse action is limited, as explained under the *Legal Actions Under The Plan's Benefit Programs And Non-Plan Programs* heading in the ***General Plan Information And ERISA Rights*** *section* of this SPD.

2. **Appointing An Authorized Representative.**
   A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. A purported assignment of benefits by a Participant to a provider (which is not permitted by the Plan) will not constitute the appointment of that provider as an authorized representative. To appoint a representative, a Participant must complete a form acceptable to the Plan Administrator (or Claims Administrator). In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator (or Claims Administrator), in writing, to the contrary.

3. **Compliance With The Patient Protection and Affordable Care Act Of 2010 And DOL Regulations.**
   The provisions of this Paragraph apply notwithstanding any contrary provision of any Benefits Booklet or any other document or communication with respect to any of the Plan's Benefit Programs. Each of the group health plan components of the Plan are intended to comply with the Patient Protection and Affordable Care Act of 2010 (the "Act") and applicable Department of Labor regulations, as interpreted by the Plan Administrator.

## Physical Examination And Autopsy

1. **Physical Examinations.**

The Plan reserves the right to have a physician of its own choosing examine any Participant whose condition, illness or injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

2. **Autopsy.**
With respect to any of the Plan's Benefit Programs, the Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

## Coordination of Benefits

### Coordination With Other Plans

If a Participant is covered under the medical and/or dental Benefit Programs and Other Plans, the benefits paid under all the plans involved may not exceed a Participant's Allowable Expenses. Benefits payable under the Other Plans are included in the determination, whether or not a claim has been made to the Other Plans.

When coordinating benefits, one of the plans is considered the "primary plan," and all the Other Plans are secondary plans. The primary plan will pay benefits without regard to the secondary plans. The secondary plans will coordinate their payments so that total benefits from all plans do not exceed the Allowable Expenses. No plan will pay more than it would have paid in the absence of these coordination of benefits provisions. The Plan is secondary in the following situations.

1. One of the Other Plans cover the Claimant as an employee.

2. For Children's expenses, one of the Other Plans cover the parent whose birthday (month and day of birth, not the year of birth) occurs earlier in the calendar year.

3. For Children's expenses when parents are separated: (a) if one of the Other Plans cover the parent who, pursuant to a court decree, is financially responsible for the Child's health care expenses; and (b) if there is no court decree, if one of the Other Plans cover the parent with custody of the Child.

4. If any of the Other Plans don't have coordination of benefits provisions, one of the plans without the coordination of benefits provisions is the primary plan.

5. One of the Other Plans have covered the Claimant longer than he or she has been covered under the Plan.

6. The Claimant is receiving COBRA and one of the Other Plans cover the claimant as an employee (or as a dependent of the employee).

Participants must provide the Plan with all the information the Plan requests with respect to the Other Plans and benefits provided (or possibly payable) by the Other Plans. If the Plan paid benefits in excess of the amount provided under these provisions, the Plan has the right to recover the overpayments from any person, insurance company or other organization.

## Coordination With Medicare

The Plan will be the primary payer for a Participant who is covered under the Plan by reason of his or her current employment status with Luxottica North America.

The Plan will be the primary payer for a disabled Participant who is Entitled To Medicare but still participates in the Plan by reason of current employment status.

The Plan will be the primary payer for a Participant who is Entitled To Medicare solely on the basis of having end-stage renal disease ("ESRD"). However, Medicare will be the primary payer for an individual with ESRD after the expiration of the period that begins on the date the individual first becomes Entitled To Medicare Part A benefits (under Social Security Act §226A) and ends 18 months later.

Medicare pays primary to this Plan (the Plan pays Secondary) for Participants who are enrolled in Medicare (either Part A or B) if:

- Your Plan coverage is not because of Your "current employment status" (as defined by federal law, i.e., COBRA) with a Participating Employer;
- You are eligible for Medicare because You are disabled, and You are not covered under the Plan because of Your "current employment status" (as defined by federal law, i.e., COBRA) with a Participating Employer; or
- You are eligible for Medicare because You have end stage renal disease, but only after the conditions and/or time periods specified by federal law are satisfied.

## Coordination With Governmental Plans

The Plan will coordinate benefits with other governmental plans and health coverage as required by applicable laws, as interpreted by the Plan Administrator.

## Subrogation and Recovery of Benefits

### General Information

Unless otherwise provided in the applicable Benefits Booklet, the provisions in this section apply to all of the Plan's Benefit Programs, and to the Non-Plan Programs, whether or not subject to ERISA.

The Plan has the right, through subrogation, to assert an Individual's claim, demand, action, or Right To Recover Against Any Other Party, with respect to the Subrogation Amount to obtain an Award, Settlement, Or Damages. The Subrogation Amount is immediately owed to the Plan and will be considered held in constructive trust for the benefit of the Plan until the Plan receives full payment of that amount.

An Individual isn't required to pursue a claim against another party. However, the Plan reserves the right to directly pursue recovery against another party on an Individual's behalf if he or she does not pursue an Award, Settlement, Or Damages against or from that party.

1. **Recovery From Awards, Settlements, Or Damages.**
   The Plan can recover the Amount Owed To The Plan from any Award, Settlement, Or Damages to which an Individual is or may become entitled as a result of an accident, a party's fault or negligence or any other circumstance under which an Individual has Right To Recover Against Any Other Party. The Plan automatically has the right of first reimbursement (or first lien) against any other parties with respect to the Amount Owed To The Plan and that amount will be considered held in constructive trust for the benefit of the Plan until the Plan receives full-payment.

   Upon receiving an Award, Settlement, Or Damages, an Individual must immediately pay to the Plan the Amount Owed To The Plan. The Amount Owed To The Plan will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing. The Plan Administrator and/or Luxottica North America may do any of the following with respect to the Amount Owed To The Plan, without anyone's consent, if that amount is not immediately paid to the Plan: (a) deduct that amount from Your present or future Plan benefits; and/or (b) deduct that amount from Your present or future benefits under any other Luxottica North America benefit plan or arrangement or from Your present or future wages. The Plan Administrator may also take these actions if You fail to disclose to the Plan Administrator the amount of any Award, Settlement, Or Damages, or You or Your legal representative fail to cooperate with the Plan.

   The Plan Administrator is also entitled to recover the Amount Owed To The Plan directly from any person or entity to whom the benefits were paid.

2. **Repayment Of Benefits Paid In Error.**
   If Plan benefits are paid in error, You must immediately repay the Plan. The Plan has the right to recover the excess amounts from You or from person or entity to whom the benefits were paid. The Plan may,

among other things: (a) deduct the excess amount from Your present or future Plan benefits; and/or (b) deduct the excess from Your present or future benefits under any other Luxottica North America benefit plan or arrangement or from Your present or future wages.

3. **Application Of The Made Whole And Common Fund Doctrines.**
The Plan precludes the operation of the "made-whole" and "common fund" doctrines, or any similar doctrines in connection with the Plan's rights of subrogation, recovery and repayment of benefits. That means, among other things, that: (a) the Plan is entitled to the right of first reimbursement (or first lien) on any Award, Settlement, Or Damages an Individual is or may become entitled to regardless of whether the Individual has been compensated for his or her damages or expenses (including his attorneys' fees or costs) and regardless of the manner in which the parties, courts, or any other entities classify or characterize the claims, recoveries, awards, settlements, or damages; and (b) the Plan's right of first reimbursement (or first lien) will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

4. **Requirement To Notify The Plan Immediately.**
An Individual must immediately notify the Plan Administrator whenever an illness, injury or condition arises as a result of an accident, a person's negligence, or any other circumstance which may entitle the Individual to an Award, Settlement, Or Damages.

5. **No Settlements Without Prior Approval.**
An Individual may not accept any settlement that does not fully compensate the Plan for the Amount Owed To The Plan. An Individual must notify the Plan Administrator in writing of any proposed settlement and obtain the Plan Administrator's written consent before signing any release or agreeing to any settlement.

6. **Separate Agreement.**
By accepting Plan benefits, an individual is entering into a separate agreement with the Plan in which he or she agrees: (a) to immediately reimburse the Plan for any Amount Owed To The Plan from any Award, Settlement, Or Damages or assign direct payment to the Plan of any Amount Owed To The Plan from any Award, Settlement, Or Damages; (b) that the "made-whole" and "common fund" doctrines, or any similar doctrines in connection with the Plan's rights of subrogation, recovery and repayment of benefits do not apply in connection with the recovery of any Amount Owed To The Plan; (c) to be bound by the Plan's provisions; and (d) to fully cooperate in protecting the Plan's rights and do nothing to prejudice those rights.

**Non-Compliance With This Section**

If an Individual takes the position that he or she has not agreed to be bound by the provisions of this section, or does not comply those provisions, the Plan Administrator, in its sole and absolute discretion with respect to the Amount Owed To The Plan (or to the Non-Plan Programs) or the Subrogation Amount, may: (1) deny

payment of any present or future claims for Plan and the Non-Plan Program benefits by, or for, the Individual up to those amounts; (2) deny or reduce any present or future benefits otherwise payable under the Plan and the Non-Plan Programs for the Individual up to those amounts; and/or (3) deny or reduce present or future benefits to which the Individual may otherwise be entitled under any other Luxottica North America benefit plan or arrangement.

**Erroneous Payments**

Providers, Participants and any other person or entity accepting, or benefiting from, the payment of Plan or Non-Plan Program benefits agrees to be bound by the terms of the Plan and the Non-Plan Programs. This includes, but is not limited to, submitting benefit claims in accordance with state health care practice acts, Medicare guidelines, other applicable laws or standards, and other standards approved by the Plan Administrator.

The Plan Administrator has the right to recover (from the recipient and/or from the Participant on whose behalf the payment was made) payments that should not have been paid under the terms of the Plan and the Non-Plan Programs, or payments payable (or made) in connection with benefit claims that were not properly submitted. Erroneous payments also include, but are not limited to, payments made: (1) pursuant to a misstatement made to obtain coverage; (2) pursuant to a misstatement in a proof of loss; (3) pursuant to a fraudulent act; (4) with respect to an ineligible person; (5) in anticipation of obtaining a recovery in subrogation if a Participant fails to comply with the Plan's and the Non-Plan Programs' provisions regarding subrogation; or (6) pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or illness to the extent that such benefits are recovered.

A Participant, Provider, health plan, Insurer, or any other person or entity who receives an erroneous payment, or on whose behalf the payment was made, is responsible for repaying the erroneous amount to the Plan and the Non-Plan Programs no later than 30 days of the earlier of discovery or demand unless otherwise provided by the Plan Administrator, or may incur prejudgment interest.

The Plan Administrator also has the sole authority to decide whether the repayment must be made in a lump sum or deducted from a Participant's other present or future benefit claims. As a condition of participating in the Plan and the Non-Plan Programs, each Participant authorizes any deductions from other benefit claims.

If legal action is necessary to recover an erroneous payment, the recipient of the erroneous payment must reimburse the Plan and the Non-Plan Programs for legal expenses that it incurred.

## General Plan Information and ERISA Rights

### Plan Name/Type of Benefits Provided

1. **Plan Name.**
   The Plan's name is the Luxottica Group Benefit Plan.

2. **ERISA Benefits.**
   The Plan is a group benefit plan which provides the following welfare Benefit Programs: (a) medical; (b) hospital indemnity insurance; (c) dental; (d) Health Care Flexible Spending Accounts; (e) Life and AD&D; (f) short term disability insurance; (g) long term disability; (h) vision; (i) employee assistance benefits; (j) business travel insurance; and (k) the voluntary benefits (to the extent covered by ERISA).

3. **Non-ERISA Benefits.**
   The Plan's Dependent Care Flexible Spending Account Benefit Program, and pre-tax premium payment feature, and the Non-Plan Programs, are non-ERISA benefits. As such, they are not subject to ERISA and the ERISA rights and requirements described in this SPD, including the provisions described in the ***Claims And Appeals Procedures*** section of this SPD.

### Plan Sponsor/Employers

Luxottica Retail North America Inc. is the Plan Sponsor. Luxottica Retail North America Inc., along with the following affiliated companies, adopted the Plan for their eligible Associates and are considered their employer: (1) Luxottica U.S. Holdings Corp., (2) Luxottica Sun Corp.; (3) Luxottica USA LLC.; (4) EYEXAM of California, Inc.; (5) LensCrafters International, Inc.; (6) Luxottica North America Distribution LLC; (7) EyeMed Vision Care LLC; (8) glasses.com Inc.; (9) The Optical Shop of Aspen; (10) Sunglass Hut Trading, LLC and (11) Foreign Affiliates, but only with respect to its Foreign Associates who are Participants as determined by the Plan Administrator.

These adopting employers are referred to collectively or individually (as indicated by the context) throughout this SPD as "Luxottica North America." With respect to an Associate, Luxottica North America means the entity listed above by whom he or she is employed or was employed most recently.

Luxottica Retail North America Inc.'s employer identification number ("E.I.N.") is 31-1339854, and its address and telephone number are:

4000 Luxottica Place

Mason, Ohio 45040

(866) 431-8484

The addresses, telephone numbers and E.I.N.'s for the companies that adopted the Plan may be obtained by calling the Luxottica Human Resources Service Center at the telephone number in the ***Contact Information*** section of this SPD.

**Plan Number/Plan Year**

The Plan Number for the Plan is 522. The Plan Year for the Plan is the calendar year.

**Plan Effective Date**

The Plan was originally effective January 1, 2007. It has been amended various times. This SPD summarizes the material provisions of the Plan as of January 1, 2016.

**Participation**

Only those individuals who satisfy the Plan's eligibility provisions and properly enroll in the Plan are considered Participants.

**Electronic Communications**

By accepting Plan benefits, You and Your Covered Family Members give Luxottica North America consent to provide to You and Your Covered Family Members (including legal representatives) through e-mail, or other electronic media, any Plan-related reports, statements, notices or other documents.

**Plan Funding**

1. **General.**

   The Plan provides both Company Funded and Insured Benefit Programs.

2. **Company Funded Benefit Programs.**

   There is no special fund, trust or insurance from which benefits are paid for the Company Funded Benefit Programs. The cost of the Benefits and administrative expenses will be funded by the contributions (or premiums) from Participants and from Luxottica North America. Luxottica North America may or may not elect to purchase a stop-loss insurance policy to finance large claims under the Company Funded medical Benefit Programs. A stop-loss carrier would not directly pay benefits under

those Benefit Programs. Instead, the stop-loss carrier would pay Luxottica North America consistent with the Company Funded status of those Benefit Programs. Any stop-loss coverage is not intended to be a Plan asset, as defined under ERISA.

3. **Insured Benefit Programs.**

Benefits under the Insured Benefit Programs are funded, and fully Insured, pursuant to contracts between Luxottica North America and the Insurers identified in this SPD. Premiums for those insurance contracts are paid by Participants and Luxottica North America.

4. **Participant Contributions/Premiums.**

The amount of Participants' contributions (or premiums) will be determined by the Plan Administrator. The Plan Administrator may generally change the amount Participants must contribute (or pay in premiums) at any time.

If eligible, You may elect to pay Your required contributions (or premiums) for coverage under certain Benefit Programs on a pre-tax basis. You can learn more about this Plan feature by reading the ***Section 125 Benefits, Flexible Spending Accounts and Health Savings Account*** section of this SPD.

## Plan Service Of Legal Process

The Plan's agent for service of legal process is the Plan Administrator. The Plan Administrator may be served at the following address.

Luxottica Group ERISA Plans Compliance and Investment Committee
4000 Luxottica Place
Mason, Ohio 45040

## Plan Administration

Luxottica Group ERISA Plans Compliance and Investment Committee, as Plan Administrator and a Plan fiduciary, intends on administering the Plan in accordance with its terms and applicable laws. The Plan Administrator has delegated some of its administrative duties to third parties as described below.

1. **Company Funded Benefit Programs.**

The Plan Administrator delegated certain claims and administrative duties under the Plan's Company Funded Benefit Programs to third party administrators who are identified in this SPD. Those third party administrators are referred to throughout this SPD as "Claims Administrators" with respect to the Company Funded Benefit Programs.

2. **Insured Benefit Programs.**

Benefits under the Insured Benefit Programs are solely determined, administered, and Insured by the applicable Insurer. Luxottica North America is not responsible for determining, administering, funding,

or paying, benefits under those Benefit Programs. The Insurers are also the Claims Administrators with respect to the Insured Benefit Programs.

3. **Assignment Of Benefits.**
The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as required by a QMCSO or unless it is specifically and clearly provided in the applicable Benefits Booklet (or similar documents) that assignment is permitted. In no event can an individual assign his or her right to receive Plan benefit payments to a health care provider.

4. **COBRA.**
COBRA coverage under the Health Benefit Programs is administered by the parties listed in the ***Contact Information*** section of this SPD.

5. **Authority.**
The Plan Administrator, and the Claims Administrators, have the maximum legal discretionary authority to interpret the Plan's provisions, to make benefit eligibility determinations, to decide disputes regarding Participants' rights, and to decide factual questions relating to the Plan. The decisions of the Plan Administrator, and the Claims Administrators, regarding the interpretation of the Plan and eligibility for Plan benefits, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Plan benefits will be paid only if the Plan Administrator, and/or the applicable Claims Administrator, determines that a Participant is entitled to benefits.

6. **Liability For Provider Actions.**
Neither Luxottica North America, nor the Plan Administrator, are liable for any act or omission of any provider. Your provider is solely responsible for the quality of the services provided to You.

## ERISA Rights

The following Benefit Programs are subject to ERISA: (1) medical; (2) hospital indemnity insurance; (3) dental; (4) Health Care Flexible Spending Accounts; (5) Life and AD&D; (6) short term disability insurance; (7) long term disability; (8) vision; (9) employee assistance benefits; (10) business travel insurance; and (11) the voluntary benefits (to the extent covered by ERISA). The Dependent Care Flexible Spending Account Benefit Program, the Plan's pre-tax premium payment feature, and the Non-Plan Programs, are not subject to ERISA.

Only Participants in the Benefit Programs subject to ERISA are entitled to the rights and protections described in 1 through 5 below with respect to those Benefit Programs.

1. **Information.**
Examine (without charge) at, the Luxottica Human Resources Service Center located in Mason, Ohio (or store location) during normal business hours, documents governing the Benefit Programs which are subject to ERISA, including a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and which is available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request (sent to the Luxottica Human Resources Service Center),

Participants may obtain copies of documents governing the operation of the Benefit Programs which are subject to ERISA, including copies of the latest annual report (Form 5500 Series) and an updated SPD. We may charge a reasonable amount for the copies.

2. **COBRA.**
In certain situations, Participants may continue their Health Benefit Program coverage under COBRA if there is a loss of coverage because of a Qualifying Event. Participants must pay the Total Contribution Amount plus an administrative charge. If You have questions about COBRA, You should review the ***COBRA*** section of this SPD, call the Luxottica Human Resources Service Center, or COBRA administrator, at the telephone numbers in the ***Contact Information*** section of this SPD, or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). The EBSA's Addresses and telephone numbers are available through EBSA's website at www.dol.gov/ebsa.

3. **Prudent Actions By Fiduciaries.**
ERISA imposes duties on the people responsible for operating the Benefit Programs which are subject to ERISA. Those people, called "fiduciaries," have a duty to operate those Benefit Programs prudently and in the interest of Participants. No one, including Luxottica North America, may fire a Participant, or discriminate against a Participant, to prevent the Participant from obtaining benefits or exercising his or her ERISA rights.

4. **Enforcement Of ERISA Rights.**
If a Participant's claim for benefits under a Benefit Program subject to ERISA is denied or ignored (in whole or in part) the Participant has a right to know why that was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time limits. Under ERISA, Participants can enforce these rights. For example, if a Participant requests a copy of Plan Documents or the latest annual report from the Plan Administrator and does not receive them within 30 days, the Participant may file suit in a federal court, provided the Participant first exhausted the claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of this SPD. In such a case, a court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a state or federal court, provided the Participant has first exhausted the claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of the SPD. In addition, if a Participant disagrees with the Plan Administrator's decision (or lack thereof) concerning the qualified status of a medical child support order, the Participant may file suit in federal court, provided the Participant has first exhausted the claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of this SPD. If fiduciaries misuse assets, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court, provided , to the extent permitted by law, the Participant first exhausted the claims and appeals procedures described in the ***Claims And Appeals Procedures*** section of this SPD. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay those costs and fees. If the Participant loses, the court may order the Participant to pay those costs and fees (for example, if it finds the Participant's claim is frivolous).

5. **Assistance With Questions.**
   If a Participant has any questions about the Plan, he or she should contact the Luxottica Human Resources Service Center at (866) 431-8484. If a Participant has any questions about this statement or about his or her rights under ERISA, he or she should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the 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, DC 20210. A Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Legal Actions Under The Plan's Benefit Programs And Non-Plan Programs

Legal action, or similar action, relating to the Plan, or any Benefit Program, or Non-Plan Program, or a claim for benefits, or any other adverse determination, under any Benefit Program, or Non-Plan Program, may not be brought by a Participant or his or her Dependents or beneficiaries (or their representatives) against the Plan, Luxottica North America, any affiliated company, a third party administrator which provides (or provided) services to the Plan, or an Insurer which provides (or provided) Insured benefits and/or services under the Plan any later than the date provided in the applicable Benefit Program's Benefits Booklet. If a Benefit Program, or a Non-Plan Program, does not provide for such a date in its Benefits Booklet, such legal action, or similar action, may not be brought, to the extent permitted by law, any later than 1 year after the date that the internal claims/appeals process (if any) for the applicable Benefit Program or Non-Plan Program has been exhausted. This section is not applicable to any legal actions, or similar actions, brought by the Plan, Luxottica North America or an affiliated company against any party (including those who provided services to or benefits under the Plan or a Non-Plan Program, or those claiming benefits under the Plan or Non-Plan Program).

No Plan, or Non-Plan Program, provision will be considered to be waived, and there will be no estoppel against the enforcement of a Plan, or Non-Plan Program, provision, except pursuant to a written instrument of the party charged with the waiver or estoppel. No written waiver will be considered a continuing waiver unless specifically stated in the waiver, and each waiver will operate only with respect to the specific term or condition waived, and will not constitute a waiver of a term or condition for the future or as to any act other than the act specifically waived.

## Plan Modification, Amendment and Termination

Notwithstanding any contrary provision in this SPD or any other document, and notwithstanding any contrary written or oral representations made by any individual, the Plan Administrator may, in its sole and absolute discretion, at any time, amend, revise, modify, or terminate the Plan (and/or particular Benefit Programs) and the Non-Plan Programs. This includes, but is not limited to, the right to change, increase, or decrease Associate contributions and/or premiums, or Luxottica North America's contributions, at any time. No consent is required on the part of any Participant, or anyone else, for the Plan Administrator to take any of these actions. The Plan (and/or particular Benefit Programs) and the Non-Plan Programs may not be amended, revised or modified orally or by any course or purported course of conduct. The Plan (and/or particular Benefit Programs) and the Non-Plan Programs can only be amended, revised or modified in a writing intended by the Plan Administrator to be an amendment, revision or modification. All amendments,

revisions and modifications to, or termination of, the Plan (and/or particular Benefit Programs) and the Non-Plan Programs are effective as of a date established by the Plan Administrator.

**No Contract Of Employment**

The Plan and the Non-Plan Programs are not intended to be a contract, or other arrangement, between anyone and Luxottica North America giving that person the legal right to continue his or her employment with Luxottica North America.

**Assistance For Foreign Speaking Participants**

If a foreign speaking Participant has difficulty understanding any part of this SPD, he or she should contact that Plan Administrator for assistance.

## Definitions

The following terms, where capitalized, have the meanings set forth below unless otherwise indicated by the context.

**Accredited School**
An accredited college, university, or business or technical schools (or through correspondence classes offered by those institutions) which has satisfied the academic standards of an educational or professional agency approved by the U.S. Office of Education, the National Commission of Accrediting or by state Optical Boards.

**AD&D**
The Insured Accidental Death and Dismemberment Benefits offered under the Plan.

**Allowable Expenses**
For purposes of the ***Coordination Of Benefits*** section of this SPD, any necessary, reasonable and customary expenses for services which are at least partially covered under the Plan. If none of the plans involved consider expenses as necessary, reasonable and customary charges, the expenses are not Allowable Expenses.

**Amount Owed To The Plan**
For purposes of the ***Subrogation And Recovery Of Benefits*** section of this SPD, Plan Benefit Payments (or Non-Plan Program benefit payments) plus other costs in related to collecting Plan Benefit Payments (or Non-Plan Program benefit payments) from a third party or an Individual.

**Approved Course**
An Eligible Class or Eligible Degree Program that is approved by Luxottica North America.

**Associate**
Whether an individual is an Associate for purposes of being eligible for the Plan is determined in accordance with 1 through 4 below. A determination by any entity (including courts and governmental entities) has no

bearing on the determination of whether an individual is an Associate for Plan purposes if Luxottica North America does not consider the individual to be an eligible Associate for Plan purposes.

1. **General.**
   To be an Associate, an individual must perform services for Luxottica North America as a common law employee and who is considered by Luxottica North America to be an Associate for purposes of the Plan. An individual who performs services for Luxottica North America as an independent contractor, leased employee, an employee of a temporary agency, or an individual in any other capacity not considered by Luxottica North America to be an eligible Associate for Plan purposes, will not be an eligible Associate retroactively or prospectively for Plan purposes.

2. **Collectively Bargained Associates.**
   An individual is not considered an eligible Associate for Plan purposes if he or she is covered by a collective bargaining agreement (or similar agreement) between union representatives and Luxottica North America ("Collective Bargaining Agreement"), unless the Collective Bargaining Agreement specifically requires coverage under one or more of the Plan's programs. In that situation, the individual is only considered an Associate for Plan purposes with respect to the programs under which the Collective Bargaining Agreement requires him or her to be covered.

3. **LensCrafters International, Inc. Associates.**
   a. Puerto Rico Associates. Associates employed in Puerto Rico by LensCrafters International, Inc. are considered Associates for all Plan purposes.

   b. Canadian Associates. Associates employed in Canada by LensCrafters International, Inc., are only considered Associates for purposes of eligibility for the: (i) complimentary eyewear benefits under the vision Benefit Program; (ii) GeoBlue Expatriate coverage under the medical Benefit Program; (iii) GeoBlue Expatriate coverage under the dental Benefit Program; (iv) GeoBlue Expatriate coverage under the AD&D Benefit Program; (v) employee assistance Benefit Program but only with respect to Full-Time Associates and Part-Time Associates; and (vi) business travel insurance Benefit Program. Associates employed in Canada by LensCrafters International, Inc. are not eligible for benefits under the Plan except for those described in (i) through (vi) above.

4. **Foreign Associates.**
   Unless otherwise provided by the Plan Administrator, a Foreign Associate is considered an Associate for Plan purposes only with respect to the Plan's programs for which other similarly situated non-Foreign Associates of Luxottica North America with whom he or she is on a job assignment are eligible, unless otherwise provided by Luxottica North America.

**Award, Settlement, Or Damages**

For the purposes of the ***Subrogation And Recovery Of Benefits*** section of this SPD, an amount including, but not limited to: (1) a full or partial award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or other payment of any kind; (2) an amount paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise; (3) an amount paid in a lump sum, installment, or annuity payments; and (4) amounts of any type, kind, nature, or character,

regardless of whether the amount identifies or covers the Plan Benefit Payments, otherwise relates to health benefits, or is specifically limited to certain kinds of damages or payments.

**Beneficiary**
A person designated by a Participant (or under the terms of the Plan) who is or may become entitled to Plan benefits, and who is indicated in the Plan's records as a Beneficiary.

**Benefit Programs**
The following Benefit Programs are currently offered under the Plan for eligible Associates and Family Members.

1. **Medical.**
   Company Funded and Insured medical and hospital indemnity coverage options.

2. **Dental.**
   Company Funded and Insured dental coverage options.

3. **Life And AD&D.**
   Insured basic and supplemental life/AD&D and Insured Dependent life and Spousal life coverage options.

4. **Short Term Disability.**
   An Insured short term disability coverage option.

5. **Long Term Disability.**
   Insured long term disability coverage options.

6. **Health Care Flexible Spending Accounts.**
   Health Care Flexible Spending Accounts.

7. **Dependent Care Flexible Spending Accounts.**
   Dependent Care Flexible Spending Accounts.

8. **Vision Benefits.**
   Company Funded vision coverage.

9. **Business Travel Insurance.**
   Insured business travel insurance coverage.

11. **Voluntary Benefits (to the extent covered by ERISA).**
    Accident, critical illness Insured and group universal life coverage.

12. **Employee Assistance.**
    Insured employee assistance coverage.

**Benefits Booklet**

The current booklet that describes the current benefits provided under the Plan Benefit Programs and which are prepared by the Insurers, HMOs and Claims Administrators (as applicable). The Benefits Booklets include insurance or HMO contracts and other governing documents. The Plan Administrator has the sole discretion to determine which documents are considered the current Benefits Booklets.

**Luxottica Human Resources Service Center**
Luxottica North America's Luxottica Human Resources Service Center.

**Casual Part-Time Associate**
An Associate who is determined, by the Plan Administrator, to be regularly scheduled to work less than 20 hours a week for Luxottica North America.

**Child(ren)**
Unless otherwise provided in the applicable Benefits Booklet, a child described in any of the following categories.

1. An Associate's natural child(ren).
2. An Associate's step-child(ren).
3. An Associate's foster child(ren).
4. A child(ren) for whom an Associate is legal guardian.
5. A child(ren) who is legally adopted by, or Placed For Adoption with, an Associate.

For Participants in California, Child includes a child of a Domestic Partner to the extent required by law as determined by the Plan Administrator.

**Claimant**
A Participant or his or her legal representative.

**Claims Administrator**
With respect to a particular Benefit Program, the entity listed in the chart in the ***Eligibility*** section of this SPD. Claims Administrators' duties include reviewing claims, and appeals, recordkeeping and other administrative services.

**Code**
The Internal Revenue Code of 1986, as amended.

**Company Funded**
A benefit arrangement under which benefits are paid solely out of Luxottica North America's general assets and are not Insured.

**Coinsurance**
The shared financial responsibility for Covered Expenses between a Participant and the Plan, typically

expressed as a percentage.

**Copay**
The amounts Participants must pay at the time they receive services or purchase prescription drugs.

**Covered Associate**
An Associate who is a Participant.

**Covered Expenses**
Expenses for a Provider's usual and customary services (as determined by the Plan Administrator) provided to a Participant.

**Covered Family Members**
A Spouse, Domestic Partner and/or Dependent (as indicated by the context) who is a Participant.

**Days Of Employment**
A period of Days Of Employment as determined in accordance with the following provisions.

1. **General.**
   A period of Days Of Employment generally means a period of calendar days of uninterrupted employment as an Associate.

2. **Health Related Leaves Of Absence.**
   Any periods of health related leaves of absence are considered employment for purposes of determining an Associate's Days Of Employment under 1 above required by applicable laws as interpreted by the Plan Administrator.

3. **Designated Associates.**
   Other Associates specifically designated in writing by the Plan Administrator will receive credit for service (as determined by the Plan Administrator) for purposes of determining Days Of Employment under 1 above.

**Deductible**
A specified dollar amount that must be satisfied, either individually or combined by Covered Family Members, for each calendar year before the Plan pays benefits for certain Covered Expenses.

**Dentist**
An individual who is duly licensed to practice Dentistry or perform oral surgery in the state where the dental Service is performed and who is operating within the scope of their license. A physician will be considered a Dentist when he or she performs the services described in the applicable Benefits Booklet and is operating within the scope of his or her license.

**Dependent**
Unless otherwise provided in the applicable Benefits Booklet, Dependent means an individual who is either a "Dependent Child" or a "Household Dependent" as defined in 1 or 2 below.

1. Dependent Child.
   A Child who is under age 26 or is a Disabled Child.

2. Household Dependent.
   An individual who satisfies the following requirements.

   a. The individual is at least age 19.

   b. The individual had the same principle place of abode as the eligible Associate, and has been a member of the eligible Associate's household (in a relationship that does not violate local laws), for at least 12 months, and intend to continue in that arrangement for the calendar year.

   c. The eligible Associate provides more than ½ of the individual's support for the calendar year as described in Code §152(d).

   d. The individual is not a "qualifying child" (as defined in Code §152(c)) with respect to anyone for the calendar year.

   e. The individual is not eligible for Medicare, or over age of 65.

**Dependent Care Expenses**
Expenses incurred by a Participant which satisfy the following requirements.

1. Are incurred for the care of a Qualifying Dependent of a Participant or for related household services.

2. Are paid or payable to a Dependent Care Service Provider.

3. Are incurred to enable the Participant and his or her spouse to be gainfully employed (or to seek gainful employment) for any period for which there are one or more Qualifying Dependents with respect to the Participant.

Dependent Care Expenses do not include expenses incurred for services outside the Participant's household for the care of a Qualifying Dependent unless the Qualifying Dependent is described in 1 above or regularly spends at least eight hours each day in the Participant's household. Dependent Care Expenses will be deemed to be incurred at the time the services to which the expenses relate are rendered.

**Dependent Care Flexible Spending Account**
A separate account maintained on behalf of a Participant for purposes of reimbursing Dependent Care Expenses.

**Dependent Care Service Provider**
A person who provides care or other services described in the definition of Dependent Care Expenses, but do not include: (1) a dependent care center (as defined in Code §21(b)(2)(D)) unless the requirements of Code §21(b)(2)(C) are satisfied; or (2) certain individuals who are related to You (as described in Code §129(c)), such as any Dependent under age 19, Your former spouse and anyone for whom You could claim a deduction under Code §151(c).

**Disabled Child**
Unless otherwise provided in the applicable Benefits Booklet, for purposes of determining if an individual is a Dependent Child, a Child is a Disabled Child if he or she satisfies the following requirements.

1. The Child is unable to engage in any substantial gainful occupational activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.

2. The Child became physically or mentally disabled prior to the attainment of age 26 and was a Participant prior to the attainment of age 26 and continuously thereafter.

3. Proof of the disability is provided as required by the IRS.

   A Child is considered a Disabled Child until the earliest of the following occur.

   a. The Child is no longer a Disabled Child.

   b. The Child becomes covered by another group plan or government plan (if permitted by law).

   c. The Child ceases to be a Participant due to other provisions of the Plan.

   d. The Participant, who is the Child's parent, fails to properly provide the Plan Administrator with proof of the Child's disability and Dependent status in the manner described below.

      A Participant must furnish proof of a Child's disability and Dependent status to the Plan Administrator within 30 days of a Child's 26th birthday. The Plan Administrator may subsequently require, at reasonable intervals, proof of a Child's disability and Dependent status, and may request to have the Child examined by a provider chosen by the Plan Administrator. If, upon the Plan Administrator's request, a Participant fails to provide proof, or refuses to permit the examination of the Child, the Child will no longer be considered a Disabled Child and will no longer be a Dependent as of the first day of the month which is on or after the date the Child is no longer considered to be a Disabled Child by the Plan Administrator.

**Domestic Partner**
An individual who satisfies the requirements in (1) through (9) below.

1. The individual and the eligible Associate have registered as Domestic Partners or entered into a civil union under state law, or satisfy the requirements of (2) through (9) below.

2. The individual and the eligible Associate are both at least age 18.

3. Neither the individual, nor the eligible Associate, is currently married.

4. Neither the individual, nor the eligible Associate, has a different Domestic Partner.

5. Neither the individual, nor the eligible Associate, is related by blood so close as to prohibit marriage.

6. The individual and the eligible Associate are mentally competent to consent to a contract.

7. The individual had the same principle place of abode as the eligible Associate (unless otherwise provided by the Plan Administrator), and has been a member of the eligible Associate's household (in a relationship that does not violate local laws), for at least 12 months, and intends to continue in that arrangement for the calendar year.

8. The individual and the eligible Associate are in an exclusive, intimate, committed relationship that is intended to be permanent.

9. The individual and the eligible Associate share a mutual obligation of support and responsibility for each other's welfare.

**Eligible Child**
A Child who: (1) is under 18; or (2) is physically or mentally incapable of caring for himself or herself. A child of an Associate's Spouse is not an Eligible Child.

**Eligible Class**
A Job Related class taken at an Accredited School. Eligible Classes include those taken in preparation for the high school equivalency test (GED). Eligible Classes do not include vocational, sports, or hobby classes, workshops, seminars, forums or clinics (unless given for academic credit by an accredited institution), classes towards a Doctorate degree, audited classes, and foreign language classes (unless the foreign language is considered necessary in the Associate's present job or expected future assignments, or is a required part of an Eligible Degree Program).

**Eligible Degree Program**
Job Related programs which result in an associate, bachelor or master's degree at an Accredited School. There is no time limit for completion of degree programs and Associates may take courses over non-consecutive quarters/semesters. Eligible Degree Programs include those in accounting, business administration, computer sciences, economics, management, marketing, merchandising, optometric related and organizational development. Eligible Degree Programs do not include those in art history, agriculture, classics, dentistry, languages, physical education, photography, religious studies and social work.

**Eligible Expenses**
An Associate's out of pocket tuition and lab fees determined after all financial aid is subtracted. Sources of financial aid include student aid programs, scholarships, fellowships and Veterans Administration payments. Eligible Expenses do not include fees for books, tools, supplies, registration, travel, meals, lodging, tutoring and other related charges.

**Entitled To Medicare**
An individual is Entitled To Medicare if he or she either is receiving Medicare benefits, or would receive Medicare benefits if he or she applied to the Social Security Administration for Medicare benefits.

**ERISA**
Employee Retirement Income Security Act of 1974, as amended.

**Family Members**
An Associate's Spouse, Domestic Partner and/or Dependent (as indicated by the context).

**Flexible Spending Account**
A Health Care Flexible Spending Account or Dependent Care Flexible Spending Account (as indicated by the context).

**Foreign Affiliate**
A company affiliated with Luxottica Retail North America Inc. which is headquartered outside of the United States and Puerto Rico.

**Foreign Associate**
An Associate who satisfies the following requirements.

1. The Associate is employed by a Foreign Affiliate.
2. The Associate is on a job assignment with Luxottica North America.

**Full-Time Associate**
An Associate who is determined, by the Plan Administrator, to be regularly and consistently scheduled to work at least 30 hours a week for Luxottica North America. This also includes an Associate who is determined to be a "full-time employee" under the rules adopted by the Plan Administrator in accordance with the provisions of the Patient Protection and Affordable Care Act of 2010.

**Health Benefit Program**
The medical, dental, vision, Health Care Flexible Spending Account and employee assistance Benefit Programs.

**Health Care Flexible Spending Account**
A separate account maintained on behalf of a Participant for purposes of reimbursing Qualifying Health Care Expenses.

**Health Savings Account (or HSAs)**
Health Savings Accounts (or HSAs) are tax-favored accounts set up in eligible Participants' names in connection with the HDHP to hold Participants' HSA contributions. Health Savings Accounts are not part of the Plan and are not subject to ERISA.

**HIPAA**
The Health Insurance Portability and Accountability Act of 1996.

**HIPAA Special Enrollment Period**
The following enrollment periods.

**1. Loss Of Other Coverage.**

Enrollment in the medical and dental Benefit Programs is permitted for You, Your Spouse and/or Dependent (as applicable) if otherwise eligible to participate in those Benefit Programs if:

a. You, Your Spouse and/or Dependent (as applicable) had alternate medical and/or dental coverage (including COBRA coverage) when You previously had the opportunity to enroll in those Benefit Programs; and

b. the alternate medical and/or dental coverage ended because of: (i) loss of eligibility for non-COBRA coverage (for reasons other than failure to pay contributions, or for cause); (ii) another company stopped making company contributions for non-COBRA coverage; or (iii) in the case of COBRA coverage, the coverage ended because the entire COBRA coverage period was exhausted.

2. **New Dependent.**
Enrollment in the medical and dental Benefit Programs is permitted if You acquire a Spouse or Dependent through marriage, birth, adoption or Placement For Adoption.

3. **Loss Of Eligibility For Medicaid Or SCHIP Coverage.**
Enrollment in the medical and dental Benefit Programs is permitted for You, Your Spouse and/or Dependent (as applicable) if otherwise eligible to participate in those Benefit Programs if You, Your Spouse and/or Dependent (as applicable) lose eligibility for Medicaid or coverage under a state children's health insurance program.

4. **Eligibility For A Premium Assistance Subsidy From Medicaid Or SCHIP.**
Enrollment in the medical and dental Benefit Programs is permitted for You, Your Spouse and/or Dependent (as applicable) if otherwise eligible to participate in those Benefit Programs if You, Your Spouse and/or Dependent (as applicable) become eligible for a premium assistance subsidy under the Plan from Medicaid or a state children's health insurance program.

**Individual**
For purposes of the Subrogation And Recovery Of Benefits section: (1) a Participant; (2) former Participant; or (3) individual receiving (or who received) Plan coverage due to COBRA, USERRA or any similar laws. Individual also includes the guardians and estates of any of the individuals described in (1) thorough (3)

**In Network**
Means a Provider who is in a network of one of the Benefit Program's PPO coverage options.

**Insured or Insured Benefit Program**
A Benefit Program under which benefits are determined, administered, and fully insured by, an Insurer pursuant to an insurance contract, with Luxottica North America. Luxottica North America is not responsible for determining, administering, or paying, benefits under this type of benefit arrangement.

Any medical loss ratio rebate paid in connection with any health insurance policy pursuant of which benefits are paid under the Plan belong to Luxottica North America unless otherwise designated by Luxottica North America.

**Insurer**
The applicable insurance company which insures and administers (or insured and administered) an Insured Benefit Program pursuant to contract with Luxottica North America. The Insurer is also considered the Claims Administrators with respect to the Insured Benefit Program.

**Job Related**
Any Eligible Class or Eligible Degree Program that helps an Associate measurably improve current job performance, or that will contribute towards the Associate's potential career development with Luxottica North America. The following factors are considered when determining if an Eligible Class or Eligible Degree Program is Job Related: (1) the Associate's career development plan; (2) the Associate's training/development goals in the annual review; (3) whether the knowledge/skills learned improve current performance; (4) whether the knowledge/skills learned contribute towards the Associate's potential career development at Luxottica North America; (5) whether the knowledge/skills learned benefit the Associate's store/department; and (6) whether the knowledge/skills learned benefit Luxottica North America.

**Leave Of Absence**
Any paid or unpaid Leave Of Absence by an Associate which is authorized by Luxottica North America in accordance with its personnel policies.

**Luxottica North America**
Luxottica North America means the entity described below by which an Associate is, or was most recently, employed: (1) Luxottica Retail North America Inc.; (2) Luxottica U.S. Holdings Corp.; (3) Luxottica Sun Corp.; (4) Luxottica USA LLC.; (5) EYEXAM of California, Inc.; (6) LensCrafters International, Inc.; (7) Luxottica North America Distribution LLC; (8) EyeMed Vision Care LLC;(9) glasses.com Inc.; (9) The Optical Shop of Aspen; (10) Sunglass Hut Trading, LLC; and (11) Foreign Affiliates, but only with respect to their Foreign Associates who are Participants as determined by the Plan Administrator.

**Medically Necessary or Medical Necessity**
Services and supplies which are determined by the Plan Administrator to be medically appropriate

**Medicare**
The program of Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act.

**Non-Plan Programs**
The tuition reimbursement program, adoption assistance program and Health Savings Accounts are described in this SPD but are not legally considered part of the Plan.

**Other Plans**
For purposes of the ***Coordination Of Benefits*** section of this SPD, any of the following plans and arrangements: (1) group insurance or any other arrangement for coverage of individuals or a group on an insured or uninsured basis; (2) any prepayment coverage to which an employer or labor union makes contributions; (3) a labor management trusteed plan, union welfare plan, employer organization plan or employee organization plan; (4) a governmental program or coverage required to be provided by statute, unless the program specifically excludes coordination or represents coverage for students sponsored by or provided through a school or other educational institution; or (5) coverage for expenses due to accidental

bodily injury or illness where payment as a judgment, settlement or otherwise is made by any person or persons considered responsible for such injury or illness or by their Insurers.

**Out Of Pocket Maximum**
A specified maximum dollar amount that must be paid for a calendar year by a Participant before the Plan generally pays for 100% of Covered Expenses for that year.

**Participant**
An Associate and/or his or her eligible Spouse or Domestic Partner, and Dependents, who are properly enrolled in, and covered under, the Plan and/or the Non-Plan Programs (as applicable) as determined by the Plan Administrator.

**Part-Time Associate**
An Associate who is determined, by the Plan Administrator, to be regularly scheduled to work between 20 and 29 hours a week for Luxottica North America.

**Part-Time Grandfathered Associate**
An Associate who is determined, by the Plan Administrator, to be a part-time hourly Associate who participated in the 1996/1997 pilot program which made him or her eligible for Full-Time Associate medical and dental coverage options

**Part-Time Option**
The Benefit Program coverage options for which for Part-Time Associates and Casual Part-Time Associates are eligible and which is Insured by the Insurer listed in the chart in the ***Eligibility*** section of this SPD.

**Placed For Adoption or Placement For Adoption**
The assumption and retention by an Associate of a legal obligation in the state of the Associate's domicile for total or partial support of a minor in anticipation of adoption of the minor. A minor's placement with an Associate ends on the termination of an Associate's legal obligation.

**Plan**
The Luxottica Group Benefit Plan, as amended. For purposes of the nondiscrimination testing rules under Code §§105(h) and 125, the Plan may be treated as a single or multiple plans for testing purposes.

**Plan Administrator**
The Luxottica Group ERISA Plans Compliance and Investment Committee and its successors.

**Plan Benefit Payments**
For purposes of ***Subrogation And Recovery Of Benefits*** section of this SPD, the amount of previous benefit payments from the Plan (or Non-Plan Program), or benefit payments that will be made (or, if greater, the reasonable value of the previous payments or payments that will be made) to or on behalf of an Individual.

**Plan Document**
This SPD, together with the Wrap Plan Document, Section 125 Plan Document and the Benefits Booklets, constitute the Plan Document. The Plan Administrator has the sole discretion to determine which

documents are considered the Plan Document.

**PPO**
The Benefit Program options which provide a health or dental care delivery system which has a network of Providers.

**Pre-Existing Condition**
A condition (whether physical or mental), regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 90-day period ending on the Participant's enrollment date. Pre-Existing Conditions do not include a pregnancy. Also, genetic information cannot be treated as a Pre-Existing Condition if there is no diagnosis of a related condition. The Plan's Pre-Existing Condition limitation does not apply to a Covered Associate or Family Member who is under the age of 19.

**Provider**
Any authorized person or entity providing health care (which includes medical, dental, vision, counseling) services to a Participant within the scope and authority granted by a Participant and the licensing board with authority over the person or entity.

**Qualified Adoption Expenses**
Reasonable and necessary expenses directly related to the adoption of an Eligible Child. Qualified Adoption Expenses include agency and placement fees, legal fees and court costs, an Eligible Child's medical expenses incurred prior to the adoption, travel expenses (including expenses for meals and lodging), immigration, immunization and translation fees, and other expenses directly related to the adoption (as determined by Luxottica North America). Qualified Adoption Expenses do not include expenses incurred prior to January 1, 2007, expenses in excess of the Plan's $5,000 lifetime reimbursement limit, expenses incurred to adopt an ineligible individual, such as a Spouse's child, expenses incurred as part of a surrogate parenting arrangement, expenses incurred in violation of state, federal or other applicable laws, expenses reimbursed by another source and expenses that Luxottica North America determines are not qualified.

**Qualified Beneficiary**
An Associate and his or her Family Members who were covered under the medical, dental, vision, and/or Health Care Flexible Spending Account Benefit Programs on the day before a Qualifying Event. A Qualified Beneficiary may include a Child who is born to or Placed For Adoption with the Covered Associate during a period of COBRA coverage or a Child covered under the Plan because of a QMCSO. A Covered Associate can only be a Qualified Beneficiary if the Qualifying Event is the termination of his or her employment with Luxottica North America (for any reason other than gross misconduct), or a reduction in his or her hours of employment with Luxottica North America.

**Qualified Medical Child Support Order or QMCSO**
A medical child support order that gives an alternate recipient the right to receive medical and dental Benefit Program coverage to which a Dependent is entitled under the Plan. For an order to be a QMCSO, it must contain the following items.

1. The name and last known mailing address (if any) of a Participant or eligible Associate and the name and mailing address of the alternate recipient covered by the order.

2. A reasonable description of the type of medical and dental coverage to be provided by the Plan to the alternate recipient, or the manner in which the type of coverage is to be determined.

3. The period of coverage.

4. The Plan's name.

A national medical support notice ("NMSN") will be considered a QMCSO if it contains the following items.

1. Contains the following information: (a) name of an issuing state agency; (b) name and mailing address (if any) of a Participant or eligible Associate; (c) name and mailing address of the alternate recipient (or the name and address of a substituted official or agency); and (d) identity of an underlying child support order.

2. Identifies either the specific type of medical or dental coverage or all available coverage. If the Plan Administrator receives an NMSN that does not designate either specific types of medical or dental coverage, or all available coverage, the Plan Administrator will assume that all are designated.

3. Informs the Plan Administrator that, if the eligible Associate is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any).

4. Specifies that the period of coverage may end for the alternate recipient only when similarly situated Dependents are no longer eligible for medical and dental coverage under the Plan, or upon the occurrence of certain specified events.

An order will not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908.

**Qualified Status Change Event**

Qualified Status Change Events generally include the following events (as applicable to the particular Benefit Program) as determined by the Plan Administrator.

1. A change in a Participant's (or eligible Associate's) marital status including marriage, death of a Spouse, divorce and legal separation and amendment.

2. A change in a Participant's (or eligible Associate's) number of Dependents including birth, death, adoption, Placement For Adoption and legal guardianship.

3. A change in the employment status of a Participant (or eligible Associate's), his Spouse or Dependents including termination or commencement of employment and a change from part-time to full-time status (or vice versa) that make him eligible or ineligible for coverage or, if applicable, coverage under the Spouse's or Dependents' employer's plan.

4. An event that causes an individual to satisfy or cease to satisfy the Plan's Dependent requirements.

5. A change in residence which affects benefit coverage for purposes of the Plan's pre-tax premium payment feature only.

6. A significant change in the cost of coverage for purposes of the Plan's pre-tax premium payment feature and Dependent Care Flexible Spending Account Benefit Program only (unless the cost change is imposed by a Dependent Care Service Provider who is related to a Participant under Treas. Reg. §1.125-4(f)(2)(iv)).

7. A significant curtailment (or addition or significant improvement) of coverage for purposes of the Plan's pre-tax premium payment feature and Dependent Care Flexible Spending Account Benefit Program only.

8. A change in coverage under another employer's plan for purposes of the Plan's pre-tax premium payment feature and Dependent Care Flexible Spending Account Benefit Program only.

9. A loss of group health plan coverage under a governmental or educational institution plan for purposes of the Plan's pre-tax premium payment feature only (with respect to payments for health coverage).

10. A loss of eligibility for Medicaid or coverage under a state children's health insurance program, or becoming eligible for a state premium assistance subsidy under the Plan from Medicaid or a state children's health insurance program.

11. A loss of health coverage, or becoming eligible for health coverage, under Medicaid or Medicare for purposes of the Plan's pre-tax premium payment feature (with respect to payments for health coverage) and Health Care Flexible Spending Account Benefit Program only.

12. HIPAA Special Enrollment Period rights for purposes of the Plan's pre-tax premium payment feature only (with respect to payments for health insurance coverage).

13. A Participant is eligible to enroll in coverage through an exchange pursuant to the rules under the Patient Protection and Affordable Care Act of 2010.

14. An event regarding incorrect elections and/or contributions, pursuant to the IRS informal policies and regulations (if any) as interpreted by the Plan Administrator.

15. Any other event designated by the Plan Administrator that is consistent with the Code and applicable Treasury Regulations as interpreted by the Plan Administrator.

**Qualifying Dependent**
An individual described in any of the following categories.

1. A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1).

2. A tax dependent of the Participant as defined in Code §152 who is physically or mentally incapable of

self-care and who has the same principal place of abode as the Participant for more than half of the calendar year.

3. A Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the calendar year.

Notwithstanding the foregoing, in the case of divorced parents, a Dependent who is a Child shall, as provided in Code §21(e)(5), be treated as a Dependent of the custodial parent (within the meaning of Code §152(e)(3)(A)) and will not be treated as a Dependent of the non-custodial parent.

**Qualifying Event**
Any of the following events which occur when the Associate and his or her Family Members, are covered under the medical, dental, vision, and/or Health Care Flexible Spending Account Benefit Program.

1. The Associate's death.

2. The Associate's termination of employment with Luxottica North America (other than by reason of gross misconduct).

3. A reduction of the Associate's hours of employment with Luxottica North America.

4. The Associate gets divorced or legally separated.

5. The Associate becomes Entitled To Medicare.

6. An individual ceases to satisfy the Plan's definition of Dependent.

Losing Plan coverage for any other reason, is not considered a Qualifying Event. Examples of events that may cause the loss of Plan coverage but are not considered Qualifying Events by themselves include the failure of an Associate to pay premiums in a timely manner, engaging in fraudulent, improper, or dishonest actions and discovering that an individual is ineligible during an eligibility audit.

**Qualifying Health Care Expense**
An expense incurred by a Participant, or by his or her Spouse or Dependent, for medical care as defined in Code §213(d), but only to the extent that the Participant or his or her Spouse or Dependent incurring the expense is not reimbursed for the expense through insurance or otherwise. Qualifying Health Care Expense does not include any premium paid for health coverage under any plan maintained by Luxottica North America or any other employer.

**Rescission**
A Rescission occurs if an individual's Plan coverage is retroactively cancelled for reasons other than failure to pay premiums or contributions toward the cost of Plan coverage.

**Right To Recover Against Any Other Party**
For purposes of the ***Subrogation And Recovery Of Benefits*** section of this SPD, that an Individual has the right to recover damages or expenses from another party, such as an individual, partnership, corporation,

government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for directly or indirectly causing or contributing to the Individual's injury or illness. This includes the Individual's rights to recover from his or her insurance carrier pursuant to any type of insurance policy, program, plan or arrangement.

**SCHIP**
State Children's Health Insurance Program, as amended. SCHIP is also commonly known as the Children's Health Insurance Program or "CHIP."

**Section 125 Plan Document**
The document prepared by Luxottica North America which governs the Benefit Programs that are described in the ***Section 125 Benefits, Flexible Spending Accounts and Health Savings Account*** section of this SPD, as amended.

**Spouse**
Unless otherwise provided in the applicable Benefits Booklet, a person who satisfies the requirements in 1 through 3 below. However, an individual who satisfies the requirements in 1 and 2 below will be considered the Spouse of a Foreign Associate.

1. Is an Associate's wife or husband pursuant to a legal union as husband and wife evidenced by a validly issued marriage license (does not include common-law marriages).

2. Is not legally separated or divorced from the Associate.

3. Has the same principle place of abode as the eligible Associate, unless otherwise provided by the Plan Administrator.

**Subrogation Amount**
For purposes of the ***Subrogation And Recovery Of Benefits*** section of this SPD, Plan Benefit Payments and attorneys' fees plus other costs related to the Plan asserting rights on an Individual's behalf.

**Total Contribution Amount**
The sum of the contributions made by Luxottica North America and an Associate for coverage under a particular Benefit Program.

**We, Us or Our**
Luxottica North America and/or the Plan, as indicated by the context in which the word was used.

**Wrap Plan Document**
The wrap plan document for the Luxottica Group Benefit Plan, as amended.

**Year Of Employment**
Years Of Employment are determined in accordance with the following provisions.

1. General. Years Of Employment generally means a period of 365 calendar days of uninterrupted employment as an Associate.

2. Health Related Leaves Of Absence. Any periods of health related leaves of absence are considered employment for purposes of determining an Associate's Years Of Employment under 1 above in accordance with applicable laws.

3. Designated Associates. Other Associates specifically designated in writing by the Plan Administrator will receive credit for service (as determined by the Plan Administrator) for purposes of determining Years Of Employment under 1 above.

**You, Your or Yourself**
An eligible Associate or an eligible Associate who is a Participant, as indicated by the context in which the word is used.

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