VISION PLAN

SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES REPRESENTED

BY

THE UNITED GAS WORKERS' UNION, LOCAL 69, UWUA, AFL-CIO

INTRODUCTION

Dominion Transmission, Inc. and Hope Gas, Inc. d/b/a Dominion Hope (collectively, the "Company") offer the Vision Plan to provide coverage for routine eye examinations, lenses, and frames.

The Plan provides two levels of benefits, Out-of-Network and In-Network benefits. With Out-of-Network benefits, you use any vision provider you choose, submit claim forms, and receive a scheduled dollar amount for each covered service. You are responsible for any costs over that amount. If you use a Davis Vision Network provider, you receive benefits under the In-Network level and claim forms are not required.

The Vision Plan does not cover medical care for your eyes, such as for an eye infection or injury. This coverage is provided by your medical plan.

Benefits described in the Summary Plan Descriptions (SPDs) are current as of the date indicated at the bottom of the page. The Company may subsequently provide additional materials that supplement, update or amend the SPDs which will provide you with information regarding changes to your benefits.

You and the Company share the cost of coverage and services actually received.

Please see the "Additional Information" Summary Plan Description document for details on other rights pertaining to your participation in the Company's Benefit Plans.

TABLE OF CONTENTS

Page

ELIGIBILITY....3–3

Coverage Categories 3–4

ENROLLMENT 3–5

CHANGING YOUR COVERAGE....3–5

Qualifying Life Events....3–5

Rehire/Reinstate 3--8

YOUR COST OF COVERAGE....3–8

WHAT THE PLAN COVERS 3–8

WHAT THE PLAN DOES NOT COVER....3–11

COORDINATION OF BENEFITS 3–11

SPECIAL COVERAGE RULES 3–12

Leave of Absence 3–12

When Coverage Ends....3–12

COBRA 3–13

FILING CLAIMS....3–13

Appeal and Review Process 3–13

CHANGING OR TERMINATING THE PLAN 3–15

PLAN DOCUMENTS 3–15

ELIGIBILITY

Regular full-time employees of the Company who are represented by The United Gas Workers' Union Local 69, UWUA, AFL-CIO are eligible to enroll for vision benefits. In addition, you may also enroll your eligible dependents in vision benefits. Eligible dependents include your:

- **Spouse** or **domestic partner**.
- **Children** (defined as your natural children, legally adopted children, children placed with you for legal adoption, foster children and stepchildren) who are under age 26
- Your **disabled children** age 26 or older, provided:
    - they became disabled before age 26;
    - they were enrolled in the Plan at the time they became disabled (or, in the case of a newly-hired employee with a child that is already disabled, the child was covered under the previous employer's medical or vision plan immediately prior to being covered under the Company's plan and is enrolled immediately upon the employee's employment);
    - they remain continuously enrolled in the plan following the disability; **and**
    - they qualify as your dependent for tax purposes (i.e., you can claim them as dependents on your federal income tax return for the year).*

    For this purpose, "disabled" means permanently and totally disabled by Social Security Administration standards applicable to children, which generally means that the child is very seriously limited in his or her activities by reason of a medically determinable physical or mental impairment that can be expected to result in death or to last for at least 12 months. Employees may be required from time to time to provide proof of the child's continuing disability.
- Your **legal ward** up to age 26 for whom you are appointed legal guardian or legal custodian, provided that they qualify as your dependent for tax purposes.*

Dependents (other than your children who are under age 26) who are serving in the military of any country cannot be covered under the plan. Children of domestic partners also cannot be covered under the plan, unless they are otherwise qualified as your dependents under the plan.

*It is your responsibility to ensure that your disabled child or legal ward qualifies as your dependent for tax purposes before enrolling or continuing to enroll him or her in the Plan. For a detailed explanation of the requirements for tax dependent status, see IRS Publication 17, Your Federal Income Tax, available at www.irs.gov.

Domestic Partner:
You may also enroll your domestic partner on an after-tax basis. You pay the full cost of coverage for your domestic partner. There is no Dominion subsidy toward the cost of this coverage. You may cover a domestic partner if both you and your domestic partner:
Are age 18 or older,

- Have resided with each other for at least six months before the effective date of coverage and intend for the relationship to be of unlimited duration,

- Are not married to anyone else or involved in another domestic partner relationship,
- Share financial responsibilities through joint ownership or lease responsibilities of their residence, and/or have named each other as beneficiaries under life insurance policies or wills.
- Are not related by blood to such a degree that marriage would be prohibited under applicable state law (without regard to gender),
- Are competent to make contracts (i.e., are not considered incompetent because of physical or mental disability).

Eligibility Verification
All employees must provide, upon request, written proof of eligibility of their dependents who are covered or who are requesting coverage under the Plan. Such written proof of eligibility must be submitted within the timeframe communicated by the Plan Administrator. Such proof of eligibility may include, but is not limited to, marriage certificates, birth certificates, adoption certificates and federal tax returns. Lack of response to a request for written documentation and/or documentation found to be fraudulent in nature may result in a loss of coverage as well as disciplinary action, up to and including termination of employment.

COVERAGE CATEGORIES
You can choose coverage from six categories for your vision benefits. These options will give you the opportunity to pick the coverage that best meets you and your family's needs. The coverage categories are:

- Employee Only
- Employee and Spouse
- Employee and Child(ren)
- Employee and Family
- Employee and Domestic Partner
- Employee and Child(ren) and Domestic Partner

EMPLOYEE SPOUSES/DOMESTIC PARTNERS
If you and your spouse or domestic partner are both employees of the Company or any other Dominion Resources, Inc. (DRI) subsidiary, you cannot be covered as both an employee and a dependent under a DRI-sponsored vision plan. Also, your children cannot be covered by both parents. When enrolling for vision benefits, you have two options:

- One spouse/domestic partner can sign up for coverage with the other as a dependent; or
- Both you and your spouse or domestic partner can sign up for coverage separately (with only one individual enrolling eligible children as dependents).

You may choose to waive vision coverage. If you waive coverage, you will not be able to enroll in Company-sponsored vision coverage until the next annual Open Enrollment, unless you experience a Qualifying Life Event.

ENROLLMENT

NEW HIRE
Your first day of work with the Company is your employment date. You can enroll in the Vision Plan at that time.

- If you enroll within 31 days following your employment date, coverage will start as of your employment date. Any vision expenses you had *before* your employment date, however, will not be covered.

- If you do not enroll within 31 days following your employment date, you cannot enroll in the Vision Plan until the next annual Open Enrollment unless you experience a Qualifying Life Event.

You will be able to enroll electronically in the Vision Plan through Your Benefits Resources (YBR). You can access YBR directly at http://resources.hewitt.com/dominion. Enrollment must be completed within 31 days of your employment date. Alternatively, you may also contact the Dominion Benefit Center (DBC) at 1-877-434-6996 with questions or if you prefer to enroll via telephone.

Annual Open Enrollment takes place in the fall of each year. It is the time when you can change your vision benefit elections. Changes you make will be effective the following January 1.

CHANGING YOUR COVERAGE

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event, you are permitted to change your vision coverage elections during the middle of a plan year without waiting until the next Open Enrollment period. Depending on the event, you can add or drop coverage or change your enrollment level (e.g., You Only to You + Family coverage).

An event will be considered a Qualifying Life Event only if it affects your, your spouse's or domestic partner's, or your child's eligibility under this Plan or the vision plan of another employer. Changes you make following a Qualifying Life Event must be on account of and consistent with the event.

Following is a listing of the types of changes that are permitted following the various Qualifying Life Events.* In addition to the changes described below, you may drop coverage for your domestic partner at any time during the year, regardless of whether you experience a Qualifying Life Event.

Event	Enrollments Permitted	Cancellations Permitted
Dependent child events		
Birth, adoption, placement for adoption, appointment of legal guardianship, or death	• Add newly eligible child • Enroll self, spouse or domestic partner, newly eligible child and other child(ren)	• Drop deceased child
Satisfying or ceasing to satisfy eligibility requirements	• Add newly eligible child and other children	• Drop newly ineligible child

{S0575687.1}

Event	Enrollments Permitted	Cancellations Permitted
Qualified Medical Child Support Order	• Add child(ren) required by QMCSO • Enroll self, and child(ren) required by QMCSO	• Drop child(ren) if QMCSO requires spouse to provide coverage (and spouse does so) • Drop child(ren) if QMCSO terminates or expires
Domestic partner events		
Satisfying or ceasing to meet domestic partner eligibility requirement (including death of domestic partner)	• Add newly eligible domestic partner	• Drop newly ineligible or deceased domestic partner
Domestic partner's change in employment or benefit eligibility status**	• Add domestic partner who lost coverage under their employer's plan	• Drop domestic partner who became covered under their employer's plan
Domestic partner's employer no longer contributes to their group vision coverage	• Add domestic partner	N/A
Employee events		
Employee's change in employment status**	• Enroll self, spouse or domestic partner, and children who became eligible under this Plan	• Drop self, spouse or domestic partner, and children who lost eligibility under this Plan
Other coverage events		
Open enrollment (non-calendar year) in other employer's plan	• Enroll self, spouse or domestic partner, and children whose coverage was dropped under other plan	• Drop self, spouse or domestic partner, and children whose coverage was added under other plan
Loss of governmental or tribal group vision coverage	• Add spouse, domestic partner or children who lost other coverage • Enroll self, spouse, domestic partner, or children who lost other coverage	N/A
Relocation of spouse or domestic partner or children to or from another country	• Add spouse or domestic partner and children who moved to the U.S.	• Drop spouse or domestic partner and children who moved out of the U.S.

Event	Enrollments Permitted	Cancellations Permitted
Spouse events		
Marriage	• Add spouse and children • Enroll self, spouse and children	• Drop self and children, if coverage is obtained under spouse's plan
Divorce, annulment or death of spouse	• Add children, if coverage is lost under spouse's plan • Enroll self and children, if coverage is lost under spouse's plan	• Drop spouse
Spouse's change in employment or benefit eligibility status **	• Add spouse and children who lost coverage under spouse's plan • Enroll self, spouse and children who lost coverage under spouse's plan	• Drop self, spouse and children who became covered under spouse's plan
Spouse's employer no longer contributes to their group vision coverage	• Add spouse and children who lost subsidy under spouse's plan • Enroll self, spouse and children who lost subsidy under spouse's plan	N/A

* These rules will be interpreted and administered in accordance with IRS rules and regulations.
**Changes in employment status that cause a gain or loss of eligibility under this Plan or your spouse's or domestic partner's plan may include: termination or commencement of employment, commencement of or return from unpaid leave, change in status such as full-time to part-time (or vice versa) and similar events. FMLA or USERRA rules may also apply if unpaid leave is family and medical leave or military leave, respectively.

IMPORTANT! When you experience a Qualifying Life Event, you must contact the Dominion Benefit Center at 1-877-434-6996 **within 31 days of the event ***, If your event does not allow a benefit change, you will have to wait until the next annual Open Enrollment to make a change to your benefits.

* The enrollment period to add dependent children is 60 days in the event of the birth, adoption or placement for adoption of your dependent child(ren.); eligibility for premium assistance under the plan through a state children's health insurance program (CHIP); or the termination of Medicaid or CHIP coverage due to loss of eligibility. The 31-day period remains in effect for adding dependents under all other qualifying life events.

Qualifying Life Event changes take effect as follows:

- **Adding** coverage – coverage begins on the date of the Qualifying Life Event.
- **Canceling coverage** – your last day of coverage is the last day of the month in which your Qualifying Life Event occurred.

REHIRE/REINSTATE

Solely to the extent required by IRS regulations, if you terminate employment and return to work for the Company in an eligible category for benefits enrollment, your benefit enrollment election depends on the number of days you did not work for the Company:

- If you return to work in 31 days or less from the termination date, your benefit elections are the same elections that were in effect on the termination date. If the same benefit election(s) are not available, you are eligible to make a new election, but only for the plan that changed, if another plan is available; or
- If you return to work after 31 days from the termination date, you are required to make new benefit elections.

YOUR COST OF COVERAGE

Contributions for employee, child and family coverage under the Vision Plan will be deducted from your pay on a pre-tax basis. Contributions for domestic partner coverage are in addition to the employee's level of coverage and are on an after-tax basis. Your contributions may vary from year to year and will depend on the category of coverage you select (You Only, etc.).

WHAT THE PLAN COVERS

The Vision Plan covers eye exams, prescribed corrective lenses, and frames (including prescription safety glasses) for you and your covered dependents.

Out-of-Network

You can go to any provider of your choice and receive benefits at the Out-of-Network level of benefits. The Plan pays Out-of-Network benefits based on the total cost of an item or service up to a maximum scheduled amount for that item or service. You must pay the provider directly for all charges and then file a claim form.

In-Network

Vision care services received from an EyeMed Vision Care network provider are covered at the In-Network level of benefits and claim forms are not required.

To find a provider via the Web, go to the EyeMed Vision Care website at www.eyemedvisioncare.com and choose SELECT from the "Select Network" drop-down box. Enter your zip code and click "Let's Go"

To find a provider by phone, call 1-855-273-4537 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you

Summary of Benefits

This chart illustrates the key features of the Vision Plan for 2014:

Plan Features	In-Network	Out-of-Network

		Reimbursement
Exam with Dilation as Necessary:	$0 Copay	Up to $55
Contact Lens Fit and Follow-up: Standard Premium	 Up to $40 10% off retail price	 N/A N/A
Frames:	$0 Copay; $80 Allowance; 20% off balance over $80	Up to $65
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium* Progressive Lens Tier 1 Tier 2 Tier 3 Tier 4	 $0 Copay $0 Copay $0 Copay $0 Copay $50 Copay $76 - $88 Copay $76 Copay $82 Copay $88 Copay %50 Copay; 80% of charge less $120 Allowance	 Up to $60 Up to $80 Up to $100 Up to $120 Up to $80 Up to $80 Up to $80 Up to $80 Up to $80
Lens Options (paid by the member and added to the base price of the lens): UV Coating Oversize (Upcharge) Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate – Adults Standard Polycarbonate – Children under 19 Standard Anti-Reflective Polarized Photochromic/Transitions Plastic Premium* Anti-Reflective Tier 1 Tier 2 Tier 3 Glass Grey #3 (Rx Sun) Blended Intermediate Photochromic Glass High Index Other Add-ons and Services	 $12 Copay $0 Copay $0 Copay $15 Copay $30 Copay $0 Copay $35 Copay $75 Copay $65 Copay $48 - $60 Copay $48 Copay $48 Copay $60 Copay $0 Copay $20 Copay $30 Copay $20 Copay $55 Copay 20% off retail price	 N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A
Contact Lenses instead of Eyeglass Lenses (allowance covers materials only): Conventional Disposables Medically Necessary	 $0 Copay; $110 Allowance: 15% off balance over $110 $0 Copay; $110 Allowance; Balance over $110 $0 Copay; Paid-in-Full	 Up to $100 Up to $100 Up to $100
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional price	N/A
Additional Pairs:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency: Exam Frames Standard Plastic Lenses or Contact Lenses	 Once every calendar year Once every two calendar years Once every calendar year	

*Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's medical director and are subject to change based on market conditions.
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Additional purchases and out-of-pocket discount:
Members will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses. Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.

Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive Lens not covered – fund as Bifocal Lens. Standard Progressive Lens covered – fund Premium Progressive as a Standard.

The Plan pays for covered eye exams and corrective lenses once every calendar year. Frames are covered once every other calendar year.

The following definitions may help you better understand the terms commonly used in vision care:

- An **ophthalmologist** is a doctor of medicine specializing in diseases of the eye. An ophthalmologist may perform surgery.
- An **optometrist** is a doctor of optometry who examines eyes for imbalances that can be corrected by prescription lenses.
- **Lenticular lenses** are lenses that are shaped like magnifying glasses, thick in the middle and thin at the edges.

WHAT THE PLAN DOES NOT COVER

Although the Vision Plan covers many vision services, it will not pay benefits for *all* vision services. The following chart lists some items that are not covered under the Plan. However, this is not an all-inclusive list. If you have questions about coverage under the Plan, please contact Vision Plan Customer Service at 1-855-273-4537 prior to receiving the service.

SERVICES NOT COVERED
• Special eyeglass lenses or coatings other than as listed under “Spectacle Lens Options” in the Summary of Benefits above. • Eye surgery or medical treatment (these may be covered under the Medical Plan). • Special corrective procedures or aids. • Expenses for more than one pair of glasses or contact lenses (except disposable contact lenses), unless you have a significant change in prescription or if you now have single vision lenses and bifocals are prescribed. • Replacement of lost or stolen glasses that are less than two years old. • Experimental services or supplies. • Services or supplies that are not medically necessary according to prevailing standards maintained by the insurance carrier. • Expenses you incurred before your coverage began. • Expenses covered under Workers’ Compensation. • Lenses or frames you receive after your coverage terminates, unless they were ordered as part of an eye exam you received while still covered, and you receive them within 30 days after coverage terminates.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you have vision coverage through the Company and another employer’s group plan.

Under the Vision Plan’s coordination of benefits provision, benefits from this and any other plan are coordinated so that benefits from both plans will not exceed 100% of expenses actually incurred. This provision will help reduce the cost of the Plan to you and the Company.

If you are enrolled in the Vision Plan as an employee, this Plan will be primary and will pay benefits first for your expenses. Any alternate coverage you have will be considered secondary and will pay benefits second.

If your spouse or domestic partner works and has coverage through his or her employer, that coverage will be the primary coverage for *your spouse or domestic partner* and will pay benefits first for his or her expenses. If he or she is covered under this Plan, it will be considered secondary for your spouse or domestic partner and will pay benefits second.

The Vision Plan will be considered the primary plan for your *other covered dependents*, also covered by your spouse or domestic partner’s plan, only if your birthday is earlier in the year than your spouse or domestic partner’s. If you and your spouse or domestic partner share the same birthday, the Vision Plan will be the primary plan only if your coverage under the Plan has been in effect longer than your spouse or domestic partner’s coverage under the other plan.

You will be asked to provide information about your other coverages. Failure to provide this information could result in the denial of claims you submit.

This coordination of benefits provision does not affect any personal coverage purchased on your own.

SPECIAL COVERAGE RULES

There are a number of special coverage rules under the Vision Plan.

LEAVE OF ABSENCE
If you are granted an authorized leave of absence, you can continue your coverage under this Plan, provided that you continue to make any required contributions for the coverage.

WHEN COVERAGE ENDS
Coverage under the Plan will continue through the last day of the month in which any of the following occurs:

- You terminate employment with the Company.
- You retire or are placed on disability status.
- You fail to meet the eligibility requirements.
- You fail to make the required contributions to the Plan.
- Termination of the Plan causes coverage to end.

If you die, coverage will continue for your covered dependents at no cost to them until the end of the month following the month in which your death occurred.

Coverage for your spouse/domestic partner or dependents under the Plan will continue through the last day of the month in which any of the following occurs:

- You cease to be covered under the Plan.
- You divorce your covered spouse (final decree must be granted).
- Your domestic partner no longer meets the eligibility requirements (see Eligibility section for details)
- Your dependents cease to qualify as dependents under the terms of the Plan (see Eligibility section for details):
  - Coverage for children who reach the age limit will cease on the last day of the month during which they attain age 26.

When coverage ends for your spouse or dependent children, you must contact the Dominion Benefit Center at 1-877-434-6996 within 31 days of the event. Based on IRS regulations, if your enrollment change is not received within 31 days of the event when dropping a dependent, the dependent is deemed ineligible and their coverage ends, but your payroll contribution may be changed prospectively only through the end of the year.

Vision coverage is not portable and cannot be converted to an individual policy if you leave the Company.

COBRA
You and your spouse, your domestic partner or dependent children may elect to continue coverage under the Vision Plan as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) if the original coverage ends because of one of the following qualifying events:

* Your termination of employment.
* Your retirement.
* Your disability.
* A reduction in your hours of work to less than a regular, full-time status.

* Your death.
* Your divorce (final decree must be granted; your children's coverage will continue).
* Your child ceases to qualify for dependent coverage under the terms of the Plan.

For more information about COBRA coverage, please refer to the "Additional Information" section.

FILING CLAIMS

When you use an EyeMed Vision Care network provider, the provider will verify your eligibility for services and claim forms are not required.

You need to fill out claim forms for out-of-network vision expenses. The *Dominion Vision Care Claim Form* is available by calling the Dominion HelpLine at 1-877-947-4636. Complete a separate claim form for each patient.

To file a claim, complete the employee portion of the form and ask the provider — the ophthalmologist, optometrist, or optician — to complete the appropriate section. To save time and to expedite your payment, complete your part of the form correctly and completely before giving it to the provider. Then send the form directly to the administrator at the address on the form. Payment is based on the assignment of benefits.

It is your responsibility to make sure that claims are filed in a timely manner. The Claims Administrator only processes claims it receives within 12 months following the end of the year in which a service was performed.

APPEAL AND REVIEW PROCESS

Enrollment Review
You can request a review of an enrollment/coverage decision made by the Plan Administrator. You must submit your request in writing to the Benefits Manager no later than 180 days after the date you received an enrollment/coverage decision. You can submit any additional documents or written comments you feel are relevant to your request, and you can review and request copies of relevant documents from the Plan Administrator. The Benefits Manager will respond in writing within 60 days, unless special circumstances require an extension of up to 60 additional days to consider your request. You will be notified if any extension is needed.

> *Note: You should request your review as soon as possible, as missed (retroactive) employee contributions may be required.*

Vision Claims Review
If a claim for vision care benefits is denied in whole or in part, you or your dependent will automatically receive a written notice of the denial explaining:

- The specific reason for the denial;
- The specific Plan provisions on which the denial is based (including, in the case of group health plans and plans providing disability benefits, information on any internal rule, guideline, or other criteria on which the denial of benefits is based and, if the denial is based on medical necessity, experimental treatment, or similar exclusion, an explanation of the scientific or clinical reasons for the determination);

- Any additional information (such as proof of age or spouse's data) required to reconsider the claim and an explanation of why the information is needed; and
- An explanation of the Plan's appeal procedures, including your right to challenge the final determination in federal court.

After your claim is denied, you will have an opportunity to appeal the denial. You must submit your appeal to the Claims Administrator within 180 days after the date you receive the denial letter. Your appeal must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

You may also submit other written comments, documents, records or other information relating to your claim.

As part of the appeal process, you will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record or other information will be considered relevant if it:

- Was relied upon in denying the claim;
- Was submitted, considered or generated in the course of processing the claim, regardless of whether it was relied upon;
- Demonstrates compliance with the claims procedures process; or
- Constitutes a statement of Plan policy or guidance concerning the denied benefit, regardless of whether it was relied upon.

In reviewing a denied claim, the reviewer will take into consideration all comments, documents, records and other information submitted by you or your dependent in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will notify you in writing within 60 days of the decision on appeal. If your appeal is denied in whole or in part, you or your dependent will be provided a written notice that provides the same information regarding your claim as the initial denial, as set forth above.

Important: Written complaints or any questions concerning your vision plan, claims, or appeals may be filed with the Claims Administrator at the following address:

EyeMed Vision Care, LLC
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-4999

Your Contact at Dominion

If you have questions or concerns about how the Claims Administrator has processed your claim or a request for services, you should contact the Claims Administrator to understand how the claim was processed, how the Plan provisions apply, and to

determine if you or your provider needs to provide additional information. Should you still have questions or concerns, you can contact Dominion's Benefits Manager at the address below:

Dominion
Benefits Manager
701 East Cary Street
13th floor, Benefits
Richmond, VA 23219

The Benefits Manager can assist in explaining the Claims Administrator's processes, or contact the Claims Administrator to obtain more details about how your claim was processed or facilitate the exchange of information between you and the Claims Administrator.

The Claims Administrator makes and reviews all determinations as to whether vision benefits are payable under the Plan and handles appeals of denied claims or services. Claims and appeals are handled by the Claims Administrator in accordance with Department of Labor regulations. The Benefits Manager can monitor the Claims Administrator's claim and appeal process. The Benefits Manager does not review or overrule any individual determinations by the Claims Administrator.

CHANGING OR TERMINATING THE PLAN

Please see the "Changing or Terminating the Plans" section of the "Additional Information" SPD for information on the Company's ability to change or terminate the Vision Plan.

PLAN DOCUMENTS

This information has been prepared to describe the Vision Plan benefits that are available to you and your eligible dependents. If there is a conflict between this information and the official documents and contracts that govern the operations of the Vision Plan, those official documents and contracts will govern.