

Group Vision Care Plan



Group Name: JM MANUFACTURING, INC. DBA JM EAGLE
Group Number: 12279902
Effective Date: JANUARY 1, 2010

Certificate of Coverage

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Subject to the Laws of the State of New Jersey

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To be filled in by employer in the event this document is used as a Summary Plan Description:

NAME OF EMPLOYER:
NAME OF PLAN:
PRINCIPAL ADDRESS:

EMPLOYER I.D.#:

POLICY #:

PLAN ADMINISTRATOR:
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

This form is a summary of the Policy provisions and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Policy itself. A specimen copy of the Policy will be furnished on request.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER The document attached to this Certificate of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Policy.

BENEFIT AUTHORIZATION Authorization issued by the Company identifying the individual named as a Covered Person of the Company, and identifying those Plan Benefits to which a Covered Person is entitled.

COPAYMENTS Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

COVERED PERSON An Enrollee or Eligible Dependent who meets the Company's eligibility criteria and on whose behalf Premiums have been paid to the Company, and who is covered under the Policy.

EMERGENCY CONDITION A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

ENROLLEE An employee or member of Group who meets the criteria for eligibility specified under section VI. ELIGIBILITY FOR COVERAGE of the Policy.

EXPERIMENTAL NATURE Procedure or lens that is not used universally or accepted by the vision care profession, as determined by the Company.

GROUP An employer or other entity which contracts with the Company for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

MEMBER DOCTOR An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Covered Persons of the Company.

NON-MEMBER PROVIDER Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Company to provide vision care services and/or vision care materials to Covered Persons of the Company.

PREMIUMS The payments made to the Company by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Policy document maintained by your Group Administrator.

- RENEWAL DATE** The date on which the Policy shall renew or terminate if proper notice is given.
- SCHEDULE OF BENEFITS** The document, attached as Exhibit A to the Group Policy document maintained by your Group Administrator, which lists the vision care services and vision care materials coverage purchased by Group for Enrollees and Eligible Dependents.
- SCHEDULE OF PREMIUMS** The document, attached as Exhibit B to the Group Policy document maintained by your Group Administrator, which states the payments to be made to the Company by Group on behalf of a Covered Person to entitle him/her to Plan Benefits.

ELIGIBILITY FOR COVERAGE

Enrollees: To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and the Company.

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any unmarried child of an Enrollee who has not obtained the limiting age as shown on the enclosed insert, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee or other child for whom a court or administrative agency holds the Enrollee responsible.

A dependent, unmarried child over the limiting age as shown on the enclosed insert may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the Enrollee for support and maintenance.

PREMIUMS

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

PROCEDURE FOR USING THE POLICY

1. When you desire to receive Plan Benefits from a Member Doctor, contact the Company or a Member Doctor. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Plan Administrator, or Company. If this list does not cover the geographic area in which you desire to seek services, you may call or write the Company office nearest you to obtain one which does.
2. You must contact the Member Doctor directly and identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from the Company. If you are eligible for Plan Benefits, the Company will provide Benefit Authorization directly to the Member Doctor.
3. When such Benefit Authorization is provided by the Company and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of your termination of coverage or the termination of the Policy. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
4. You pay only the Copayment (if any) to the Member Doctor for the services covered by the Policy. The Company will pay the Member Doctor directly according to its agreement with the doctor.

Note: If you obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by the Company in accordance with the Non-Member Provider reimbursement schedule shown on the enclosed insert, less any applicable Copayments.

5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the attached Schedule of Benefits indicates Covered Person's Plan includes such coverage). No prior approval from the Company is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by the Company for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact the Company's Customer Service Department for assistance.

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

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

BENEFIT AUTHORIZATION PROCESS

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

BENEFITS AND COVERAGES

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

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

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under the Policy in lieu of all other lens and frame benefits described herein for the current eligibility period.
5. Necessary contact lenses, together with necessary professional services, will be provided as indicated on the enclosed insert.

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

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

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

COPAYMENT

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

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Policy maintained by your Group Administrator.

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

NOT COVERED

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

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

CHANGES IN COVERAGE

In the event of subsequent changes to coverage under the Policy, Group shall distribute notice of such changes to Enrollees.

LIABILITY IN EVENT OF NON-PAYMENT

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION POLICY OTHER THAN THOSE NOT COVERED BY THE POLICY.

CLAIMS

Member Doctors will submit claims on behalf of Covered Persons. If Plan Benefits are provided by Non-Member Doctors, the Covered Person shall pay for the services and submit a claim by submitting the receipt(s) to VSP for reimbursement for allowable expenses. Claims shall be furnished to VSP within one hundred and eighty (180) days of the date Plan Benefits are received by a Covered Person. Failure to provide such proof within such time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible.

COMPLAINTS AND GRIEVANCES

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

The Covered Person may also contact the New Jersey Department of Health and Senior Services or the Department of Banking and Insurance:

New Jersey Department of Banking and Insurance, Division of Insurance, Enforcement and Consumer Complaints
P.O. Box 329
Trenton, NJ 08625-03299
(609) 292-5316 (phone)
(800) 446-7467 (in New Jersey)
(609) 292-5865 (fax)

New Jersey Department of Health and Senior Services, Office of Managed Care
P.O. Box 360, John Fitch Plaza
Trenton, NJ 08625-0360
(609) 292-7837
(609) 292-0053 (fax)

Claim Payments and Denials

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

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

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

The Company's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative. If Covered Person disagrees with the Company's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. The Company shall resolve any second level appeal within thirty (30) calendar days.

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

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after a claim for benefits has been filed in accordance with the requirements of the Policy, and no such action shall be brought within three (3) years from the expiration of the time within which claims can be submitted as required by the Policy.

PHYSICAL EXAMINATION AND AUTOPSY

The Company shall have the right and opportunity to examine the person for whom a claim is made when and as often as it may reasonably require during the pendency of claim under the Policy and to make an autopsy in case of death where it is not prohibited by law.

TERMINATION OF BENEFITS

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

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

Plan Benefits to Eligible Dependents shall continue for 180 days after the death of the Enrollee, subject to Continuation of Coverage provisions in the Policy with respect to Enrollees or Eligible Dependents for reasons other than the death of the Enrollee.

CONTINUATION/EXTENSION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same. In the event of total disability of a Covered Person which exists as of the date of termination, the Covered Person shall have ninety days from said date to obtain Plan Benefits, subject only to the attached Schedule of Benefits.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VISION SERVICE PLAN INSURANCE COMPANY

3333 Quality Drive

Rancho Cordova, CA 95670

Group Name: JM MANUFACTURING, INC. DBA JM EAGLE

Plan Number: 12279902

Effective Date: JANUARY 1, 2010

Plan Term: TWENTY-FOUR (24) MONTHS

**VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE**

PLAN ADMINISTRATOR:

Sheryl Harris

(Name)

5200 W Century Blvd

(Address)

Los Angeles, CA 90045-5928

(City, State, Zip)

MONTHLY PREMIUM:

YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

ELIGIBILITY:

ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO AGE 19 OR TO AGE 25 IF FULL-TIME STUDENTS. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:

SIGNATURE PLAN

EXAMINATION: ONCE EVERY 12 MONTHS.

LENSES: ONCE EVERY 12 MONTHS.

FRAMES: ONCE EVERY 24 MONTHS.

TERM, TERMINATION AND RENEWAL:

AFTER THE POLICY TERM, THIS POLICY WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

TYPE OF ADMINISTRATION:

BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

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

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

PLAN BENEFITS

MEMBER DOCTOR BENEFIT

NON-MEMBER PROVIDER BENEFIT

VISION CARE SERVICES

<i>Vision Examination</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>45.00*</i>
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VISION CARE MATERIALS

Lenses

<i>Single Vision</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>45.00*</i>
<i>Bifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>65.00*</i>
<i>Trifocal</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>85.00*</i>
<i>Lenticular</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>125.00*</i>

<i>Frames</i>	<i>Covered up to Plan Allowance*</i>	<i>Up to \$</i>	<i>47.00*</i>
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Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

CONTACT LENSES

Necessary

<i>Professional Fees and Materials</i>	<i>Covered in Full*</i>	<i>Up to \$</i>	<i>210.00*</i>
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Elective

<i>Professional Fees** and Materials</i>	<i>Up to \$ 130.00</i>	<i>Up to \$</i>	<i>105.00</i>
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Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for 12 months.

****Subject to Copayment, if any.***

*****15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.***

COPAYMENT

There shall be a Copayment of \$20.00 for the examination payable by the Insured to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional \$20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.

LOW VISION

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

Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Covered in Full	Up to \$125.00
Supplemental Aids	75% of cost	75% of cost

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

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

ADDENDUM

**ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PROGRAM**

GENERAL

This Rider lists additional vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY (“VSP”) are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Diabetic Eyecare Program (“DEP”) are available to Insureds who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, and who are covered under the VSP Signature Plan®. The Diabetic Eyecare Program allows Insured’s Member Doctor to provide diagnostic services not available under the VSP Signature Plan. The Diabetic Eyecare Program does not cover medical treatment for Insureds with diabetic or any other medical conditions.

PROCEDURES FOR OBTAINING DIABETIC EYECARE PROGRAM SERVICES

Insured’s Member Doctor will provide services under the DEP as needed following Insured’s routine VSP Signature Plan eye examination. No referrals or authorizations are required for services provided under the DEP.

ELIGIBILITY

Insureds under this Program are the same as stated on the VSP Signature Plan Schedule of Benefits associated with this Rider.

COPAYMENT

A Copayment of \$5.00 is required for each Ophthalmological Service and Office Visit under the DEP, and is paid to the Member Doctor at the time of service. Other Copayments may apply to services under Insured’s VSP Signature Plan. Refer to the VSP Signature Plan Schedule of Benefits associated with this Rider.

PLAN BENEFITS

SERVICE*	MEMBER DOCTOR BENEFIT	BENEFIT FREQUENCY†	
Ophthalmological services and Office Visits	Covered in full, less \$5.00 Copayment	Once every 12 months	
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	
COVERED SERVICES (The following list is current as of [7/1/08] and is subject to change without notice.)			
Description	Procedure Code		
Ophthalmological services	92002, 92004, 92012, 92014		
Office Visits	99201 - 99205, 99211 - 99215		
Gonioscopy	92020		
Extended Ophthalmoscopy	92225, 92226		
Fundus Photography	92250		
*Service and/or diagnosis limitations apply, or certain procedures require special handling. Member Doctors must consult the <i>VSP Provider Reference Manual</i> for details before rendering services.			
†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.			

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas makes insufficient insulin or can't efficiently use it.
Fundus Photography	Taking photos of the inside of the eye that show the optic nerve and retinal vessels.
Extended Ophthalmoscopy	A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.
Gonioscopy	Use of a special contact lens to look at the eye's aqueous drainage area.

ADDENDUM

EVIDENCE OF COVERAGE & DISCLOSURE FORM

Please note the following revisions to your Evidence of Coverage and Disclosure Form. Keep this document with your Evidence of Coverage and Disclosure Form for a complete and accurate description of your benefits.

1. The following provision is added to the section titled **DEPENDENT ELIGIBILITY**:

Domestic Partners: Domestic partners of the same or opposite gender as the Enrollee shall be covered pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits. The domestic partner's unmarried dependent children are also covered provided they depend upon the Enrollee for support and maintenance.