Group Vision Care Policy

Group Name: LOS ALAMOS NATIONAL SECURITY, LLC.
Group Number: 12284390
Effective Date: JANUARY 1, 2013

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195
To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER: LOS ALAMOS NATIONAL SECURITY, LLC.
NAME OF PLAN: VISION SERVICE PLAN

GROUP #: 12284390

PLAN ADMINISTRATOR: LOU POLITO
ADDRESS: P.O. BOX 1663, MSP280, LOS ALAMOS, NM 87545

PHONE NUMBER: (505) 667-1806

Benefits are furnished under a vision care Policy purchased by the Group and provided by VISION SERVICE PLAN INSURANCE COMPANY (VSP) under which VSP is financially responsible for the payment of claims.

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. A copy of the Policy will be furnished on request.

DEFINITIONS:

ADDITIONAL BENEFITS RIDER
The document attached as Exhibit C to the Group Policy maintained by your Group Administrator, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

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

COPAYMENTS
Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

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

ELIGIBLE DEPENDENT
Any legal dependent of an Enrollee of Group who meets the eligibility criteria established by Group and approved by VSP under Section VI. ELIGIBILITY FOR COVERAGE of the Policy under which such Enrollee is covered.

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 the Group who meets the eligibility criteria specified under Section VI. ELIGIBILITY FOR COVERAGE of the Policy.

EXPERIMENTAL NATURE
A procedure or lens that is neither used universally nor accepted by the vision care profession, as determined by VSP.

GROUP
An employer or other entity that contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
VSP NETWORK DOCTOR  An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

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

PLAN or PLAN BENEFITS  The vision care services and vision care materials that a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

POLICY  The contract between VSP and Group upon which this Plan is based.

PREMIUMS  The Payments made to VSP 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 maintained by your Group Administrator, that lists the vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

SCHEDULE OF PREMIUMS  The document attached as Exhibit B to the Group Policy maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

ELIGIBILITY FOR COVERAGE

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

Eligible Dependents:  If dependent coverage is provided, the persons eligible are indicated on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

PREMIUMS  Group is responsible for payments of the periodic charges for coverage. Group will notify Covered Person of Covered Person's share of the charges, if any. The entire cost of the program is paid to VSP by Group.
PROCEDURE FOR USING THE PLAN

1. When you want to receive Plan Benefits, contact VSP or a VSP Network Doctor. A list of names, addresses and phone numbers of VSP Network Doctors in your area can be obtained from your Group, Plan Administrator or VSP. If this list does not cover the area in which you desire to seek services, call or write the VSP office nearest you to find one that does.

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

3. When such Benefit Authorization is provided by VSP, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy, in spite of your termination of coverage or the termination of the Policy. Should you receive services from a VSP Network Doctor without such Benefit Authorization or obtain services from a Non-VSP Provider, you are responsible for payment in full to the provider.

4. You pay the Copayment (if any), amounts which exceed the Plan Allowances, and any amounts for non-covered services or materials to the VSP Network Doctor for services under this Policy. VSP will pay the VSP Network Doctor directly according to its agreement with the doctor.

   **Note:** If you are eligible for and obtain Plan Benefits from a Non-VSP Provider, you should pay the provider’s full fee. You will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown on the enclosed Schedule of Benefits and Additional Benefit Rider (if applicable), less any applicable Copayments.

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 VSP Network Doctor (or Non-VSP Provider if the attached Schedule of Benefits and, if applicable, Additional Benefits Rider, indicates Covered Person’s Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If there is no Additional Benefit Rider for one of these plans attached to this Evidence of Coverage, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person’s medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP’s Customer Service Department for assistance.

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

5. In the event of termination of a VSP Network Doctor’s membership in VSP, VSP will be liable to the VSP Network Doctor for services rendered to you at the time of termination and permit the VSP Network Doctor to continue to provide you with Plan Benefits until the services are completed, or until VSP makes reasonable and appropriate arrangements for the provision of such services by another VSP Network 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 and Additional Benefit Rider (if applicable) for a summary of the level of coverage provided to Covered Person by Group.

BENEFITS AND COVERAGE

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

Specific benefits for which you are covered are described on the attached Schedule of Benefits and Additional Benefit Rider (if applicable).

COPAYMENT

The benefits described herein are available to you subject to your payment of any applicable Copayments as described in this Evidence of Coverage, the Schedule of Benefits and Additional Benefit Riders (if applicable). Amounts that exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

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 certain options, as listed in the PATIENT OPTIONS section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable), the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options' extra cost.

Some professional services and/or materials are not covered under this Plan. Please refer to the NOT COVERED section of the attached Schedule of Benefits and Additional Benefit Rider (if applicable) for details.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of our Optometric Consultants, this is necessary for the visual welfare of the Covered Person.

LIABILITY IN EVENT OF NON-PAYMENT
IN THE EVENT VSP FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE HELD LIABLE FOR ANY SUMS OWED BY VSP OTHER THAN THOSE NOT COVERED BY THE PLAN.

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

CLAIMS PAYMENTS AND DENIALS
Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
Request for Appeals: If a Covered Person’s claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person’s name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person’s authorized representative should submit all requests for appeals to:

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

VSP’s determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person’s authorized representative.

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

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

TERMINATION OF BENEFITS

After the Policy Term, this Policy will continue on a month to month basis or until terminated by either party giving the other party sixty (60) days notice. Policy Benefits will cease on the date of cancellation of this Policy whether the cancellation is by your Group or by VSP due to nonpayment of Premium.

If Covered Person is receiving service 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.

INDIVIDUAL CONTINUATION 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.

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.
GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Policy:

- Enrollee.
- The legal spouse of Enrollee.
- Any unmarried child of Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.
- A dependent parent of the same gender as Enrollee, or the opposite gender of Enrollee if one partner is over age 62, 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.

Unmarried dependent children are covered up to the end of the month in which they turn age 25.

A dependent, unmarried child over the limiting age 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 Enrollee for support and maintenance.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization Procedures.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the VSP Network Doctor or the Non-VSP Provider at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.
### PLAN BENEFITS

<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>Covered in full*</td>
<td>Up to $ 40.00*</td>
<td>Available once each 12 months**</td>
</tr>
</tbody>
</table>

Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated.
*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>LENSES</td>
<td></td>
<td></td>
<td>Available once each 12 months**</td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in full *</td>
<td>Up to $ 40.00*</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in full *</td>
<td>Up to $ 60.00*</td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in full *</td>
<td>Up to $ 80.00*</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered in full *</td>
<td>Up to $ 125.00*</td>
<td></td>
</tr>
</tbody>
</table>

Plan Benefits for lenses are per complete set, not per lens.
*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>LENSOPTIONS</td>
<td></td>
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</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>Covered in full</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Tinted/Photochromic</td>
<td>Covered in full</td>
<td>Up to $ 5.00</td>
<td></td>
</tr>
</tbody>
</table>

** Beginning with the first day of the Benefit Period.

<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRAMES</td>
<td>Covered up to Plan Allowance*</td>
<td>Up to $ 45.00*</td>
<td>Available once each 24 months**</td>
</tr>
</tbody>
</table>

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.
<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT LENSES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Fees/Materials</td>
<td>Covered in full *</td>
<td>Up to $ 250.00*</td>
<td>Available once each 12 months**</td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam, Professional Fees/Materials***</td>
<td>Up to $ 130.00</td>
<td>Up to $ 110.00</td>
<td>Available once each 12 months**</td>
</tr>
</tbody>
</table>

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.
***15% Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Doctor or Non-VSP Provider. Review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other exam, lens and frame benefits available herein.

This means that utilization of contact lens benefits exhausts all of the Covered Person's exam, lens and frame benefits for the current Benefit Period, and future eligibility for exam, lenses and frames will be determined as if exam, spectacle lenses and frames were obtained in the current Benefit Period.

<table>
<thead>
<tr>
<th>SERVICE OR MATERIAL</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>NON-VSP PROVIDER BENEFIT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW VISION</td>
<td></td>
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<tr>
<td>Professional services for severe visual problems not correctable with regular lenses, including:</td>
<td></td>
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</tr>
<tr>
<td>Supplemental Testing</td>
<td>Covered in full (Includes evaluation, diagnosis and prescription of vision aids where indicated.)</td>
<td>Up to $125.00</td>
<td>*</td>
</tr>
<tr>
<td>Supplemental Aids</td>
<td>75% of amount up to $1000.00*</td>
<td>75% of amount up to $1000.00*</td>
<td>*</td>
</tr>
</tbody>
</table>

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) Benefit Periods.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider’s full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER’S FULL FEE.
EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP’s Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

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

ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PROGRAM

GENERAL
This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayment and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Diabetic Eyecare Program ("DEP") are available to Covered Persons who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions. The Diabetic Eyecare Program does not cover medical treatment for Covered Persons with diabetic or any other medical conditions.

ELIGIBILITY
Covered Persons under this Program are the same as stated on the VSP Plan Schedule of Benefits associated with this Rider.

PROCEDURES FOR OBTAINING DIABETIC EYECARE PROGRAM SERVICES
Covered Person’s VSP Network Doctor will provide services under the DEP as needed following Covered Person’s routine VSP Plan eye examination. No referrals or authorizations are required for services provided under the DEP.

COPAYMENT
A Copayment of $20.00 is required for each Ophthalmological Service and Office Visit under the DEP, and is paid to the VSP Network Doctor at the time of service. Other Copayments may apply to services under Covered Person’s VSP Plan. Refer to the VSP Plan Schedule of Benefits associated with this Rider.

PLAN BENEFITS

<table>
<thead>
<tr>
<th>SERVICE*</th>
<th>VSP NETWORK DOCTOR BENEFIT</th>
<th>BENEFIT FREQUENCY†</th>
<th>NON-VSP PROVIDER BENEFIT**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmological services and Office Visits</td>
<td>Covered in full, less $20.00 Copayment</td>
<td>Once every 12 months</td>
<td>Up to current Non-VSP Provider Schedule of Allowances</td>
</tr>
<tr>
<td>Gonioscopy</td>
<td>Covered in full</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td>Extended Ophthalmoscopy</td>
<td>Covered in full</td>
<td>Once every 6 months*</td>
<td></td>
</tr>
<tr>
<td>Fundus Photography</td>
<td>Covered in full</td>
<td>Once every 6 months*</td>
<td></td>
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</tbody>
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COVERED SERVICES (The following list is current as of [7/1/08] and is subject to change without notice.)

<table>
<thead>
<tr>
<th>Description</th>
<th>Procedure Code</th>
</tr>
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<tbody>
<tr>
<td>Ophthalmological services</td>
<td>92002, 92004, 92012, 92014</td>
</tr>
<tr>
<td>Office Visits</td>
<td>99201 - 99205, 99211 - 99215</td>
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<tr>
<td>Gonioscopy</td>
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<tr>
<td>Extended Ophthalmoscopy</td>
<td>92225, 92226</td>
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<tr>
<td>Fundus Photography</td>
<td>92250</td>
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</tbody>
</table>

*Service and/or diagnosis limitations apply, or certain procedures require special handling. VSP Network Doctors must consult the VSP Provider Reference Manual for details before rendering services.

†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.

**Non-VSP Provider Benefits are available only to Covered Persons whose Group has purchased this option, or where such benefits are required by the laws of Covered Person’s state of residence. Covered Persons should contact their Group, or VSP Customer Service at (800) 877-7195 before obtaining services from Non-VSP Providers.
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.