Combined Insurance Company of America

111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

GROUP VISION INSURANCE POLICY

POLICY NUMBER:	9929498
POLICYHOLDER:	MAPFRE U.S.A., Corp.
STATE OF ISSUE:	Massachusetts
POLICY EFFECTIVE DATE:	January 1, 2011
POLICY ANNIVERSARY DATE:	January 1, 2012, and each January 1 thereafter

Combined Insurance Company of America agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy may be modified by mutual agreement between the Policyholder and the Company.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Carmine A. Giganti, Vice President and Secretary

THIS IS A LIMITED BENEFIT POLICY
Please read the Policy carefully.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred; or
4. if the number of eligible employees increases or decreases by more than 10%, premium will be adjusted at the end of the calendar month in which the increase or decrease occurred, unless otherwise mutually agreed.

If premiums are due the Company, or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of the current month plus three months.

Premium Rate Change. The Company has the right to change the premium rate on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change.

Grace Period. A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Return of Premium. The Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the Policyholder.

TERMINATION OF POLICY

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. on any date on or after the fourth Policy Anniversary Date. Written notice must be provided to the other party at least 31 days prior to termination;
2. the date the number or percentage of persons covered under the Policy does not meet the minimum participation requirement of 10;
3. the date the required premium has not been paid, except as provided in the Grace Period provision; or
4. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

CERTIFICATES

The Company will furnish a Certificate for each Insured to the Policyholder which will set forth the essential features of the insurance coverage.

ADDITIONAL INSUREDS

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

INCORPORATION PROVISION

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after the Policy Effective Date are made a part of the Policy.

Combined Insurance Company of America

111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

GROUP VISION INSURANCE CERTIFICATE

POLICY NUMBER: 9929498

POLICYHOLDER: MAPFRE U.S.A., Corp.

POLICY ANNIVERSARY DATE: January 1, 2012, and each January 1 thereafter

Combined Insurance Company of America represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Carmine A. Giganti, Vice President and Secretary

THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

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DEFINITIONS

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for covered Vision Examination and Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried child from birth to age 19 who is primarily dependent upon the Insured for support and maintenance; or
3. each unmarried child at least 19 years of age to 25 years of age who is primarily dependent upon the Insured for support and maintenance and who is a full-time student; or
4. each unmarried child at least19 years of age who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday.

Child includes stepchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A full-time student is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;
5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

The term "spouse", wherever used, will include a Domestic Partner.

Fundus Photography Examination means the recording of a portion(s) or complete retina surface and structures.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

IntraLase Initiated LASIK means a LASIK surgical procedure in which a special laser is used instead of a blade to create the stromal flap.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

LASEK (Laser Assisted Epithelium Keratomileusis) means a surgical procedure that utilizes a trephine to create an epithelial flap and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

Laser Vision Correction Procedures means surgical procedures which permanently alter the focusing power of the eye(s) in order to change refractive errors.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to create a stromal flap of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the stromal flap is replaced and is adhered without stitches.

Medically Necessary Contact Lenses means:
1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute towards the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frame(s)* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. 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;
5. plano (non-prescription) lenses;

6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. 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; and:
10. 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.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. on the date the Insured's coverage ends;
2. the date on which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:
1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the Office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

SCHEDULE OF BENEFITS

Policyholder: MAPFRE U.S.A., Corp.

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

Benefit	In-Network Costs	Out-of-Network Reimbursements	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Co-payment	up to $50	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$15 Co-payment	up to $42	
Bifocal	$15 Co-payment	up to $78	
Trifocal	$15 Co-payment	up to $130	
Frames	$0 Co-payment, up to $130 retail allowance	up to $74	24 months
Contact Lenses ***(only one option available per Benefit Frequency)***			12 months
Conventional	$0 Co-payment, up to $130 allowance	up to $104	
Disposable	$0 Co-payment, up to $130 allowance	up to $104	
Medically Necessary	$0 Co-payment, Paid in full	up to $210	
Lens Options			12 months
Standard Progressive Lenses (add on to Bifocal)	$80 Co-payment	up to $78	
Premium Progressive Lenses (add on to Bifocal)	$80 Co-payment, less $120 allowance	up to $78	

OUR PRIVACY PLEDGE TO YOU

Combined Insurance Company of America

Brad Bennett, President

In A Nutshell ...

We understand how important it is to protect your personal information. We want you to know that we make every effort to insure that your personal information remains just that ... personal and private! Information about you is collected and shared only as necessary to provide you with the very best support, service and product options you've come to expect from the Combined Insurance Company of America.

The Kinds Of Information We Collect

Some of the information we may collect includes: your name, residence and mailing addresses, email address, personal and business phone numbers, social security number, spouse and children names and ages, beneficiary information, occupation, other insurance, and medical history.

Where We Get Our Information

We get most of our information directly from you. Usually, the insurance application and other standard industry forms give us all the information we need. We may also get information about you from calls, letters, email and other correspondence you have with us. But sometimes, more information is necessary. For example, we may ask a doctor for more details about your medical history. We may also go to a consumer reporting agency to verify or obtain information about you such as driving record, your job duties, drug or alcohol use or dangerous sport activities.

Who Has Access To Your Information

We want you to know that we maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your personal information. And, we restrict access to your personal information to those employees who need to know such information. For example, an Underwriter to evaluate your application; a Claims Adjuster to settle your claim; or a Service Representative to answer your questions and meet your service needs.

Sometimes, we may share your information with other companies affiliated with Combined, particularly if they support our efforts to provide you with service and product information.

Sometimes, we may also share your information with a company or business not officially connected to Combined but who may do work on our behalf, or who may offer products and services we believe will be of interest to you.

And sometimes, we may disclose information about you to an insurance regulatory authority, a government agency or law enforcement.

Various industry and professional organizations may also ask us for customer information in order to conduct research studies. These studies are purely scientific in nature and never identify individuals.

Finally, if we do provide your information to any party outside of Combined we require them to abide by the same privacy standards as indicated here.

Vermont Residents - Your state law requires financial institutions to obtain your consent prior to sharing information about you with others. Except as permitted by law, we will not share information we collect about you with non-affiliated third parties or companies in our corporate family unless you authorize us to do so.

California Residents - Your state law requires financial institutions to obtain your consent prior to sharing information about you with non-affiliated third parties. Except as permitted by law, we will not share information we collect about you with non-affiliated third parties while you are a resident of California.

If You Have Questions Or Are Concerned

We hope this "Privacy Pledge To You" reassures you that Combined will not disclose personal information about you, or any current or former insured, except as permitted and/or required by law.

If you have any questions about our Privacy Policy please contact us toll free at:

1-800-225-4500

If you do not wish to be made aware of new programs and services provided by Combined nor want us to share information with Combined affiliates or with external businesses performing work on our behalf, or who may offer products and services we believe will be of interest to you, please write us at:

Combined Insurance
Attention: Compliance Manager
PO Box 6705
Scranton, PA 18505-0705

A Note About The Medical Information Bureau

Information about your insurability will always be treated as confidential by the Combined Insurance Company of America or its reinsurers however, we may make a brief report to the Medical Information Bureau about you. The MIB is a nonprofit membership organization of life insurance companies which operates an informal exchange on behalf of its members. If you apply for life or health insurance coverage to a member company or a claim for benefits is submitted, the Bureau, upon request, will supply the company with any information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Combined Insurance Company of America or its reinsurers may release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

A Note About Consumer Reports

As part of the normal procedure for processing new insurance applications, we may obtain an investigative consumer report about you. You may, if you wish, request to be interviewed in preparation of this report.

If we order a report, and you contact us in writing, we'll provide you with additional information as to the nature and scope of the report. And, if you request it in writing, you are entitled to receive a copy of the investigative consumer report from the consumer reporting agency.

To write us requesting additional information about your consumer report or to ask for a copy of the report, please write to:

Combined Insurance
Attention: Compliance Manager
PO Box 6705
Scranton, PA 18505-0705

HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This is your Health Information Privacy Notice from Combined Insurance Company of America (referred to as We or Us).

This notice provides you with information about the way in which We protect Personal Health Information ("PHI") that We have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI.

The Health Insurance Portability and Accountability Act ("HIPAA") requires Us to: Keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

Use and Disclosure of PHI

We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:

- **For Health Care Payment Purposes**: For example, We may use and disclose PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.
- **For Health Care Operations Purposes**: For example, We may use and disclose PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, care coordination, investigate and respond to complaints or appeals, provider treatment review and provision of services.
- **For Treatment Purposes**. For example, We may use and disclose PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.
- **For Health Services**. For example, We may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.
- **For Data Aggregation Purposes**. For example, We may combine PHI about many insureds to make plan benefit decisions, and the appropriate premium rate to charge.
- **To You About Dependents**. For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.
- **To Business Associates**. For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

Additional Uses or Disclosures. We may also disclose PHI about you for the following purposes:

- To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request.
- To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.

- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.
- In accordance with a valid authorization signed by you.

Your Rights Regarding PHI That We Maintain About You

You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of: **Combined Insurance Company of America, P. O. Box 6705, Scranton, PA 18505-0705**, **Attention: HIPAA Privacy Office**

- You have the right to inspect and copy your PHI. If you request a copy of the information, We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- You have the right to ask Us to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI.
- You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions.
- You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply.
- Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice.
- You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.
- You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice by calling Us at 1-800-225-4500, select HIPAA or submitting the request to the Combined Insurance Company of America, P. O. Box 6705, Scranton, PA 18505-0705 Attn: HIPAA Privacy Office.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Us. When filing a complaint, include your name, address and telephone number and We will respond. All complaints must be submitted in writing to Combined Insurance Company of America, P. O. Box 6705, Scranton, PA 18505-0705 Attn: HIPAA Privacy Office. You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Changes To This Notice

We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to insureds.

If you have any questions regarding this notice, please call 1-800-225-4500, select HIPAA or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

All questions and requests regarding your rights under this Notice should be sent to:

Combined Insurance Company of America
P. O. Box 6705
Scranton, PA 18505-0705
Attention: HIPAA Privacy Office

Combined Insurance Company of America
111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

POLICY/CERTIFICATE AMENDMENT

The rider is attached to and made part of Policy No. 9929498 issued by **Combined Insurance Company of America** to **MAPFRE U.S.A., Corp**.

Effective **January 1, 2015**, the Application for Vision Care Benefits as issued is amended as noted below:

NEW RATES:

New Rates Please refer to the attached rate sheet.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Carmine A. Giganti, Vice President and Secretary

VN AMD63007 1208

MAPFRE, U.S.A. Corporation
EyeMed Select Plan H, Fixed Fee
Voluntary
Option 2
EyeMed Vision Care in conjunction with Combined Insurance Company of America

Version 6

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$50
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$74
Standard Plastic Lenses		
Single Vision	$15 Copay	$42
Bifocal	$15 Copay	$78
Trifocal	$15 Copay	$130
Standard Progressive Lens	$80 Copay	$78
Premium Progressive Lens	$80 Copay, 80% of Charge less $120 Allowance	$78
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses		
(Contact lens allowance includes materials only)		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay; $130 allowance, plus balance over $130	$104
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	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:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	$5.77	
Subscriber + 1	$11.53	
Subscriber + Family	$15.33	

All plans are based on a 48-month contract term and 48-month rate guarantee.
Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of MA.
Fees quoted will be valid until the 1/1/2015 plan implementation date. Date quoted: 7/17/2014.
Rates assume Employer contribution of 20% or less for employees and dependents
Insured Plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) 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;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) 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; 9) Services or materials provided by any other group benefit plan providing vision care;
10) 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.

If MAPFRE, U.S.A. Corporation has chosen this benefit design, attach this document to the group application and sign here:

Signature

Date 8/25/14

TC6

EyeMed
VISION CARE

NAT

COMBINED INSURANCE COMPANY OF AMERICA
5050 Broadway, Chicago, Illinois 60640
ADMINISTRATIVE OFFICE: 4000 LUXOTTICA PLACE, MASON, OHIO 45040

Application for Vision Care Benefits

I. EMPLOYER INFORMATION

Employer Name: MAPFRE U.S.A., Corp. Tax ID #: 04-2599931

DBA Name (if other than above): _____

Business Address: 211 Main Street City: Webster State: MA Zip: 01570

Mailing Address (if other than above): _____ City: _____ State: _____ Zip: _____

Correspondent: Beverly Basak Title: Benefits Coordinator

Phone Number: (508) 949-4558 Fax Number: (508) 949-4921

E-mail Address: BBasak@commerceinsurance.com

Type of Business: ☐ Proprietorship ☒ Corporation ☐ Partnership ☐ Other (Specify): _____

Service Area: ☒ National ☐ State Specific (list): _____

If any subsidiary or affiliated companies are to be insured or any Employees are working at a location other than the address above, please explain:

_____

Will this plan replace any existing coverage? ☒ Yes ☒ No

If "Yes," indicate name and address of existing insurer:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Effective date of existing coverage: _____

If "Yes," are any Employees on COBRA continuation? ☒ Yes ☐ No How many? 12

Termination date of existing coverage (if applicable): _____

II. PLAN SELECTION

Please refer to the attached proposal page.
Vision services are arranged by EyeMed Vision Care from contracted network providers.

III. PREMIUMS

Contribution towards premium ☒ Yes ☐ No

VII. EMPLOYER INFORMATION

- Billing Contact Name: Beverly Basak Phone: (508) 949-4921
- Billing Address: 211 Main Street

City: Webster State: MA Zip: 01570

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper:

- Name
- Address
- Billing Contact and Phone Number

Employer's Premium Contribution for: Employees: 0% Dependents: 0%

Employee's Premium Contribution for: Employees: 100% Dependents: 100%

Are Employee and Dependent premiums being paid through a Section 125 Plan? ☒ Yes ☐ No

Are Employee and Dependent premiums being collected by payroll deduction? ☒ Yes ☐ No

Premium received with application: _____

Number of Participants:

Total number of employees: 1,680

Total number of dependents: 4,035

Are Domestic Partners covered under this plan? ☒ Yes ☐ No

Premiums shall be payable in advance at the rates set forth in the following Schedule of Premiums, included on the attached proposal page.

IV. ELIGIBILITY INFORMATION

Number of Full-time Employees: 3,000 Number Applying: 1,680

Eligibility Reporting Contact (produces the eligibility file): Beverly Basak

Address (if different from group): _____

City: _____ State: _____ Zip: _____

E-mail: BBasak@commerceinsurance.com Phone: (508) 949-4558

Fax: _____

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision elections for members)

Name: _____ Phone: _____

Days/Hours of Availability: _____ E-mail: _____

PROBATIONARY PERIOD

For New Employees: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☒ Other Date of Hire

Probationary Period is waived for present Employees: ☒ Yes ☐ No

Number of Employees who have not yet completed the probationary period: 0

V. EFFECTIVE DATE

1. This plan will become effective at 12:01 a.m. Standard Time at the employer's address herein, on the first day of **January**, 2011 provided that all of the following have been completed prior to this effective date:
   A. This application has been received and accepted by EyeMed (must be submitted 30 days in advance of the effective date).
   B. EyeMed has been furnished a working file of all eligible members, according to the membership layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.
   C. A check for the first month's remittance is received.

2. This plan will be effective through **December 31**, 2014 (36 months) and the premium is based on the information provided.

The Employer hereby makes application to Combined Insurance Company of America for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward premiums monthly in advance.

The Employer certifies that all the information shown on this application and any attachments are correct and complete and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling Employees may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE INSURANCE COMPANY**; and that no field representative of the Insurance Company has the authority to modify any conditions of application, or policies, by making any promise or representation. It is understood that the insurance as to any Employee will not become effective on the date insurance should otherwise become effective if he is not at work on such date performing all duties of his occupation and otherwise meets the requirements of the Insurance Company.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dated at: _____ this 18th day of Oct. 2010.

Signed for the Employer: Cathleen Reynolds Title: SVP HR

VI. MEMBER ID CARDS

Group will be receiving EyeMed ID cards: ☒ Yes ☐ No

Plan Display Name: MAPFRE USA

(Company Name as you want it to appear on all other correspondence).

Company Name as you want it to appear on the ID card. (Can only be 30 characters including punctuation, spacing & any code)
MAPFRE USA

All EyeMed ID cards are mailed directly to employees' home address

ATTENTON: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT.

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name (print): **Chandor Insurance Agency, LLC** Tax ID Number: **04-3422349**

Broker Name (print): **Carol Chandor**

Address: **177 Milk Street, Suite 310**

City: **Boston** State: **MA** Zip: **02109**

Phone: **617-570-9100** Fax: **617-570-9161**

Primary Contact: **Samantha Lombard**
Primary Contact Title: **Consultant**
Primary Contact Email: **slombard@bosben.com**

Secondary Contact: **Piper McNealy**
Secondary Contact Title: **Partner**
Secondary Cotnact Email: **pmcnealy@bosben.com**

☒Broker Signature: Carol Chandor

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name (print): _____ Tax ID Number: _____

General Agent Name (print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Primary Contact: _____
Primary Contact Title: _____
Primary Contact Email: _____

Secondary Contact: _____
Secondary Contact Title: _____
Secondary Contact Email: _____

☒General Agent's Signature: _____

EyeMed VISION CARE®

MAPFRE, U.S.A. Corporation
EyeMed Select Plan H, Fixed Fee
Voluntary
Option 1

Version 4

EyeMed Vision Care in conjunction with Combined Insurance Company of America

Vision Care Services	Member Cost	Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$50
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$74
Standard Plastic Lenses		
Single Vision	$15 Copay	$42
Bifocal	$15 Copay	$78
Trifocal	$15 Copay	$130
Standard Progressive Lens**	$80	$78
Premium Progressive Lens**	$80, 80% of Charge less $120 Allowance	$78
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay; $130 allowance, plus balance over $130	$104
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit:	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:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	$5.49	
Subscriber + Family	$13.87	

All plans are based on a 48-month contract term and 48-month rate guarantee

** Standard/Premium Progressive lenses not covered - fund as a Bifocal Lens

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid for groups domiciled in the State of MA.
Fees quoted will be valid until the 1/1/2011 plan implementation date. Date quoted: 5/11/2010.
Rates assume 100% employee contribution for employees and dependents.
Insured Plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) 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;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care;
9) 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.
10) 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.

If MAPFRE, U.S.A. Corporation has chosen this benefit design, attach this document to the group application and sign here:

Signature

Date 10/14/10

TC6